IMPROVING VA SERVICES TO VETERANS: INITIATIVES AND INNOVATIONS IN THE DEPARTMENT OF VETERANS AFFAIRS

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

AUGUST 3, 1994

Printed for the use of the Committee on Veterans' Affairs

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IMPROVING VA SERVICES TO VETERANS: INITIATIVES AND INNOVATIONS IN THE DEPARTMENT OF VETERANS AFFAIRS

WEDNESDAY, AUGUST 3, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m., in room 334, Cannon House Office Building, Hon. Lane Evans [chairman of the subcommittee] presiding.

Present: Representatives Evans, Ridge, and Everett.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Good morning and welcome. Today the subcommittee will be receiving testimony on innovative efforts to improve VA services to veterans. Our witnesses will be Hershel Gober, the decorated Deputy Secretary of the Department of Veterans Affairs, and a number of other VA employees.

As recently reported in *The American Legion* magazine, please-the-customer service is making a comeback following decades of decline as more American businesses recognize the economic benefits of good customer service.

President Clinton and Secretary Jesse Brown have both recognized and emphasized the critical importance of good customer service. In July of last year Secretary Brown initiated VA's campaign of "Putting Veterans First." More recently, President Clinton issued an Executive Order directing Federal agencies to develop customer service standards and plans. The Administration and the VA are clearly committed to making service excellence a top priority. This subcommittee strongly endorses and supports this goal.

Largely unknown, at facilities across America thousands of VA employees are working daily to improve health care services to our veterans. Sometimes the idea of a single employee becomes a better way to serve veterans. In other cases, entire facilities are working together. From these efforts many outstanding programs in the VA clearly provide first class service to veterans.

Each year, literally thousands of VA employees are recognized by both the VA and non-VA organizations for exceptional service. Too often, however, this good news about the VA receives too little attention.

Clearly, veterans programs are not receiving all the resources they could use. Together we must continue to press ahead to obtain

these funds. At the same time, the Department of Veterans Affairs must make the best possible use of the resources that are available. It doesn't always take more resources to provide better services. Available resources can be better utilized and on a smarter basis. We know this can be done because it has been done and is being done today.

In some cases it may be true that good news travels fast, but news about the VA providing better services to veterans may not travel at all. Many local initiatives that have improved services to veterans remain largely unknown—even within the VA. It is puzzling why these successful innovations are not being replicated, duplicated, and repeated throughout the VA.

If the best practices of individual facilities were used systemwide, clearly the quality of services to veterans could be quickly improved and at little or no added cost. This is a challenge that the VA must meet.

VA employees include Nobel Award winners and even an astronaut. The committee and the Department are justly proud of those employees who have achieved so much, but like most organizations, it is the individual efforts and contributions of the many, not the few, employees who ultimately determine the quality of VA services to veterans.

As noted, many VA programs providing veterans first class service exist today because of the personal initiative of only one or just a few dedicated and caring employees. Without any doubt, individual VA employees can and do make a difference. VA employees must continue to be given the tools and opportunity to improve services to veterans.

At times this subcommittee has been critical of the VA for its ineffective management, lax security, inadequate services, and other deficiencies. While calling on the VA to address these issues, this subcommittee has been constantly aware of the commitment and dedication of individual VA employees; the men and women who are motivated not by awards or public recognition, but by their personal determination to better improve services to our veterans. Today this subcommittee will receive testimony from a few of these employees who represent so many.

The subject of our hearing today is really the untold story of the efforts being made in the VA today to improve services to veterans. Because there are literally thousands of VA employees quietly working to improve services to veterans, today's hearing can highlight only a few of these efforts. These programs represent not only what is being done today but, more importantly, what can be done to improve the system throughout the Department of Veterans Affairs.

In addition to receiving information about these programs, the subcommittee also seeks to learn how the VA can routinely and systematically learn about and better publicize these programs and others like them throughout the Department of Veterans Affairs.

At this time I am very pleased to recognize the gentleman from Pennsylvania, the ranking Republican minority member, and appreciate his attendance here today.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman.

First of all, let me say to you on a personal note I don't know if there is a more active subcommittee not only in the Veterans' Affairs Committee but in the entire Congress of the United States, and I think the level of activity simply reflects a level of interest that you have demonstrated over the years, so it is a pleasure to serve with you today and to be with you today.

To those who would testify and those who are in support of those testifying, let me first congratulate you and thank you on behalf of veterans generally. As the chairman mentioned, we spend a lot of time in this committee trying to work with you to improve the quality of service we give to our Nation's veterans. Sometimes this committee is very critical, hopefully in a constructive way. It is nice to spend some time with you learning about the innovative things that you are doing and working with you hopefully to get the word out that on a day-to-day basis you continue to press to improve the quality of those services.

Total Quality Management is something that people have been talking about in the private sector for a long, long time, and it is nice to know that there are agencies within the Government who are looking for better ways to treat their customers, looking for better ways, innovative ways, to stretch those resources, those rare funding dollars, a little bit further.

As elected officials, we are all kind of in the same business together, it is a service industry, and our consumer, your consumer, is the veteran. In my judgment, there is no more important customer in the country than our Nation's veterans.

So I am very pleased to be with you today as I learn about some of the innovations that you have undertaken. Hopefully, as I said before, as you continue to engage this committee, we can challenge the VA delivery system itself to continue to examine, refine and improve the delivery mechanism to your customers, those very, very important consumers of VA services, our Nation's veterans.

So I thank you for your appearance, and I appreciate, Mr. Chairman, your calling this hearing.

Mr. EVANS. Thank you very much.

The chair now recognizes the gentleman from Alabama for any opening remarks that he might have.

Mr. EVERETT. Thank you, Mr. Chairman.

I will just ask permission to submit some remarks for the record. I want to welcome you here today, and there is not much I can add to what has already been said.

Thank you very much.

[The prepared statement of Congressman Everett appears at p. 39.]

Mr. EVANS. Thank you.

The subcommittee is both pleased and honored to welcome as our first witness, the Honorable Hershel Gober, Deputy Secretary of the Department of Veterans Affairs.

Deputy Secretary Gober is a two-term Vietnam veteran who retired from the military following a very distinguished career in the Army, the Army Reserve and Marine Corps. He covered a lot of bases in doing so.

Immediately prior to being appointed VA Deputy Secretary by President Clinton, he served as Director of the Arkansas State Department of Veterans Affairs. In 1992 he was recognized as the most effective State Director by the National Association of State Directors of Veterans Affairs.

Mr. Secretary, we look forward to your testimony this morning, and you are invited to proceed whenever you are ready.

STATEMENT OF HON. HERSHEL W. GOBER, DEPUTY SECRETARY, DEPARTMENT OF VETERANS AFFAIRS

Mr. GOBER. Thank you, Mr. Chairman. It is a pleasure to be here. I want to thank you and the members of the committee for the opportunity to appear here.

I have submitted a written statement, and I would request that it be included in the official record.

Mr. EVANS. Without objection, so ordered.

Mr. GOBER. I want to thank all of you, you and Mr. Ridge, for your comments about my fellow VA associates. Today you are going to hear from very hard working people. I think back to about a year ago, when I accompanied Mrs. Clinton to the VA medical center here, and she saw all these wonderful things that we were doing at the VA medical center. She turned to me and said, "Why does the VA keep its light under a basket? Why doesn't it take the basket off and let the light shine out?" because everybody in America that goes and gets a CAT scan, the VA did that; the pacemaker, the VA did that. The list goes on and on, and it was done by dedicated VA employees.

I am delighted to be here with them today. I have visited many of the locations that you are going to hear from today. I have never been more proud to be anything except a company commander in Vietnam than I am to be a VA employee because, as you said, these people are doing great things with no increases in the budget.

In some cases they are saving us money. They are working about as smart as they can in some locations, but they continually amaze me and, as I travel around, none of them come up to me and say, "I need more money, I need to be promoted," but they do come up to me and say, "You know, we need to do more for the veterans." When I visit these places, the volunteers will come up to me and say—punch me in the chest and say, "Boy, you need to give these people more help out here. They are working hard and you need to help them. Boy! You go back to Washington, and you tell them folks." I like that because they are praising the people. They recognize the fact that these are people who are really trying to make a difference and they are taking care of the most distinguished Americans—the veterans—the people that make it possible for me to sit here and talk to you this morning.

We should have been into courtesy and caring years ago. I think we were, but somewhere we got sidetracked like I think probably all of Government got sidetracked because we had a captive audience. If you are on your way home this afternoon and you stop by a grocery store to buy a loaf of bread or some milk, or whatever, and if you go through the checkout line and the cashier is not courteous to you, you go some place else tomorrow. You won't go there

again. That is what the veteran will be doing when health care passes, if we are allowed to participate.

It is not only from a health care standpoint, but it is the right thing to do. We have to be courteous to the veterans, and when I visit some of these facilities I see how crowded they are and how crowded the waiting rooms. It is very stressful to the veterans. They know when they go to a VA facility, they are going to have to wait. Some of them come in feeling like they are not going to be treated with courtesy. It is always a surprise to them when they come in and people do treat them courteously.

We are making a very big push. Everyone in VA will have the care and courtesy training. We have already started. The Secretary and I will have also been trained. We are really truly trying to make a difference, and we are trying to do our very simple mission. Our mission is very short. Our mission is to take care of veterans. There is no other mission, everything else is peripheral.

There might be some other things that we are supposed to do, but the number one mission we have in VA is to take care of veterans. I think you will be very pleased to hear some of the stories from the employees here today. They will tell you about the ways that they have improved the service to the veterans in the field, and they will answer your questions. There are no questions they will not answer for you. They are great minds, and they are very caring, very dedicated people.

When I go around speaking, a lot of people say, "Do you really think VA can play a role in health care reform?" I say, "Yes, we can play because you see, I've got a secret weapon. It is the people, and the people that work within the VA are dedicated." As you said earlier, dedicated, very hard working people work in VA, and they do this because they really and truly enjoy doing what they are doing.

I am delighted to be here this morning, Mr. Chairman, and I would welcome your questions.

[The prepared statement of Mr. Gober appears at p. 42.]

Mr. EVANS. Thank you, Mr. Secretary. We also appreciate your early arrival here this morning to meet with your employees. We know you are quite close to these good people that work for you as well.

Can you update this subcommittee on the VA's campaign to Put Veterans First?

Mr. GOBER. As I said earlier, the campaign has been implemented at all the hospitals and all the regional offices. They are doing it in different ways. In some facilities you enter there is a big banner that says "Putting Veterans First"; in other places they wear a little pin that says "Putting Veterans First." As you know, Secretary Brown has a lapel pin that says "Putting Veterans First," and it is just a reminder that we are doing the training in all the centers and every place we contact the public. All of our people will have that training, just like we did with sexual harassment training. Everybody from the Secretary to myself and all the way through the Department will do the same training on courtesy and caring. We emphasize to everyone to watch out because if I see an employee that is not courteous, I have an obligation to tell that person, "Hey, you are not treating this veteran properly and you

are messing with my pay check." One of these days veterans will have a choice to go some place else. We want them to come to the VA. I remember when most of our veterans were World War II guys. I grew up with those guys. I tell folks wherever I go that I remember when these guys were young and lean and mean. They were heroes. They may be old now and they may be stooped over, but they stormed the beaches at Omaha, they were at Iwo Jima, and they were like us once. You had better treat them with respect and dignity.

Mr. EVANS. How can individual VA facility innovations which provide improved services to veterans be better publicized and used more widely throughout VA hospitals?

Mr. GOBER. Would you repeat the question?

Mr. EVANS. How can individual facility innovations be better publicized and used more widely throughout the VA?

Mr. GOBER. That is a very good question. In fact, we talked about that yesterday. It is one of the most frustrating things for me, I think. We have a great ideas in New York City Regional Office that won the quality award from the Vice President. Then we have places like Albany, NY, Portland, and Grand Junction, CO, and Augusta. Great things going on in those locations, but we don't do a good job of talking to each other. I want to tell you, however, it is definitely improving.

It was just like our computer systems when we got here. I was amazed that we have all these great computer systems, yet nobody in Government can talk to each other. It doesn't make much sense to me, and I don't know anything about it, I'm just a country boy from Arkansas, but it doesn't make sense to me to have systems like that. So we started communicating about how to improve our networks, and it is getting much better. We are beginning publicizing things.

For example, we have one hospital where the average waiting time for a prescription is only 7 minutes. In other places the waiting time may be 2 hours or 3 hours. I said somebody needs to be talking to share ideas with our problem facilites. Sure, it may be a smaller hospital, but they are doing something right. The doctors, during the exam with the patient transmits the prescription to the pharmacy. When the veteran is done seeing the doctor, the prescription is filled. We need to share our better ideas.

The Secretary and I emphasize this all the time, and I can truthfully tell you that we are getting better. I spend a lot of time talking to the different people within the hospitals and the administration. We are improving, and it all has to do with just telling each other what we are doing. If you have a good idea, share it.

Mr. EVANS. The gentleman from Pennsylvania.

Mr. RIDGE. Mr. Chairman, I think the Secretary has set the table for the long list of witnesses that you have, and you have said it in such a positive way. I just want to thank you for doing that.

It is nice to see you again. I guess the challenge—and you have really talked about it in your oral remarks—is, in a system that is as huge as the VA system, where you have creative and thoughtful and dedicated people at their own VA medical centers or throughout whatever the delivery system is, thinking differently about improving services. I guess the biggest challenge you have is, when

an idea is discovered and we determine that it works, getting that idea back up the chain of command and getting that information out to the rest of those in the VA who would, I am sure, more often than not, like to employ it.

So I guess that is a continuing challenge that any huge organizational structure, public or private, will have and will continue to have. The fact that you know it is a challenge means that you are halfway there to meeting it. So I appreciate it.

Mr. GOBER. Thank you, sir.

If I may, Mr. Chairman, one thing that we are doing also is that I tell people to make mistakes. Make mistakes. Try something new because if you don't make mistakes, you are not doing anything new. You are doing it the old way, and, quite frankly, the old way doesn't work, it never did work. I never want to hear anyone say to me "we have done it this way for 20 years," because that is reason enough right there to change it. We have been to the moon and back in 20 years. That is reason enough to change it right there.

I am not encouraging people to go out and make stupid mistakes. I don't mean that. I am encouraging people to be innovative, and they are. They are being innovative, and I say, "If you make a mistake and it doesn't work, back up and try another way, you will learn from that mistake," and that is the kind of atmosphere that Secretary Brown and I want to have. We want to have an atmosphere, and we have that, where the people are totally honest, they feel like they are not going to have a reprisal taken against them for trying something new, as long as it is legal and as long as they are up front about it. I think the people at VA are feeling that, I think they honestly feel that.

People have been in my office and in the Secretary's office that never had an opportunity to come up to that floor before. I can guarantee you that. In fact, all these people are invited to my office when we leave here. I want them to go up and see the beautiful view that I have got that was left for me by the prior administration.

The point is that we have got to have an atmosphere like that where people feel like they are free to take a chance and do the innovative things that you and I both know we have to do if we are going to provide good customer service.

Mr. RIDGE. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. Thank you, Mr. Secretary. We appreciate your testimony and commend you for further taking care of your employees by taking them to see your office today.

Mr. EVANS. The members of our first witness panel are Dr. Robert Rhyne, Barry Bell, and Thomas Ayres.

Dr. Rhyne is Director of the VA Medical Center in Grand Junction, CO; Barry is Director of the VA Medical Center in Portland, OR, and it is a pleasure to welcome him before this subcommittee once again; Thomas is Director of the VA Medical Center in Augusta, GA.

Without objection, the prepared statements of each witness will be include in its entirety in the printed record. Each witness is again requested to limit his oral presentation to 5 minutes and to summarize from their prepared text as needed.

Doctor, once you are situated we will start with you.

STATEMENTS OF DR. ROBERT R. RHYNE, DIRECTOR, VA MEDICAL CENTER, GRAND JUNCTION, CO; THOMAS L. AYRES, DIRECTOR, VA MEDICAL CENTER, AUGUSTA, GA; AND BARRY L. BELL, DIRECTOR, VA MEDICAL CENTER, PORTLAND, OR

STATEMENT OF DR. ROBERT R. RHYNE

Dr. RHYNE. Thank you, Mr. Chairman.

The Grand Junction VA Medical Center is a 90-bed general medicine surgery and psychiatry level three facility serving western Colorado, eastern Utah, northwestern New Mexico, and southwestern Wyoming. The patient care issues that we deal with are much the same as those found in the rest of the VA system including acute and chronic heart and lung disease, substance abuse, cancer, AIDS. And other issues.

The metropolitan area of Grand Junction, CO, with a population of roughly 100,000, sits in a valley on the western slope of the Rocky Mountains midway between Salt Lake City and Denver, each about 250 miles away. The Grand Junction VA Medical Center is the second largest hospital in this 500-mile span. As an unaffiliated general medicine and surgery facility and because of our remote location, we provide acute comprehensive care in all disciplines except neurosurgery, invasive cardiology, and open heart surgery.

While the transfer of an acutely ill patient from New York to Washington, DC, roughly 240 miles, is rarely accomplished or even considered, our professional staff is faced with decisions concerning remote distance transfers each and every day. Because our catchment area encompasses such a large and diverse geographic area, we are treating patients with a higher level of complexity locally. Only by recruiting an extremely competent and dedicated staff have we been able to make the successful transition to primary care.

In 1987 the patient care medical services within Grand Junction were organized into two separate entities, ambulatory medicine and inpatient medicine. Prior to 1987 we operated with the general medicine clinic and the general medicine overbook clinic. These clinics functioned 5 days a week with an overcrowded waiting room and a general dissatisfaction with the service by the patients and the health care providers alike. Patients were treated again and again with overwhelming, unnecessary volumes of charts, laboratory tests, and radiological examinations were ordered during one patient visit and then the patient was scheduled for a second general medicine appointment with a different provider who asked the same questions and ordered some of the same tests. This cycle was often repeated several times.

This unsatisfactory situation was further worsened by an ever increasing workload. The internists worked longer than normal hours, the nurses and the medical administration clerks found little satisfaction in their jobs, and, more importantly, the veterans did not receive the compassionate and continuing care that they deserved. The medical center personnel clearly had no choice except to find a better way to deliver care.

As a result, a group of physicians, nurses, and medical administration service personnel developed a rather novel operating plan at least by VA standards at that time. The planning was intensive, and in July of 1988 the primary care model was introduced to Grand Junction patients. Every eligible veteran with a pending general medicine clinic appointment was immediately given an appointment with a newly formed treatment team consisting of a nurse, a physician, and a medical administration service clerk. Overnight patients in our system had a personal physician who would treat him or her in the outpatient clinic, admit and care for them as an inpatient in the hospital and, when needed, monitor them through the harrowing experiences of the intensive care unit. With time, our patients realized there was always someone within their personal treatment team they could call to discuss a problem or to make an appointment.

Each medical clerk and registered nurse was responsible for the practice of two physicians. In the past year we have added a social worker to each primary care team to take care of their nonmedical needs. The clerks and nurses work daily with the physicians, thus getting to know their styles of practice and, more importantly, getting to know them as coworkers and colleagues. In turn, the physicians finally had well trained, knowledgeable team members who wanted to make their work easier instead of increasing their frustrations.

The team concept changed everything for the better. There are numerous measurable benefits to our program. Walk-in patients who historically fill the waiting room of most VA outpatient clinics are easily accommodated by our primary care model. Since our patients have an identified team to call, there is no need for them to just walk in, and our walk-in visits have declined from 42 percent of all visits to less than 11 percent.

A wider range of health care services has been provided to an ever increasing female veteran population. We are now delivering comprehensive health care to better than 90 percent of our female patients, and we are doing so long before it was identified as a high priority of the Veterans Health Administration.

Laboratory tests have decreased by 6 percent, and outpatient radiology exams have declined by 12 percent. The physicians have learned that as they come to know their patients better they do not order as many unnecessary and duplicate tests.

Patients' satisfaction at Grand Junction VA Medical Center is high. In a recent survey we asked patients general questions such as, "Do you feel your health care team cares for you?" and, "Do you have confidence in your health care team?" On a scale of 5, with 5 being the highest, our score in this area was 4.64.

Since the inception of the ambulatory care model, nursing turnover has been nil. When all is said and done, the real success of our primary care model is demonstrated in decreased hospital admissions. While we have experienced a 38 percent increase in the number of patients treated, our medical admissions to the hospital have declined by 11 percent. We are convinced that this is a direct result of doing a better job in ambulatory care, perhaps scheduling a patient an extra time or two on an outpatient visit to avoid a costly hospital admission. We also conjecture that the emphasis we

have placed on our patient education program is reaping better health for our veterans.

In conclusion, the transition to primary care has been an interesting journey, with many detours along the way. It may sound easy as presented in this short testimony, but there have been some difficult times. It is virtually impossible to outline all the nuances of our model or to describe how it evolved. To clearly understand how it works, one must witness the model in action. We invite any and all to call or visit.

During the last 24 months, we have had site visits by professional administrative staff from other VA medical centers to see our operations firsthand. We believe our sample model is the most effective and efficient way to deliver comprehensive and continuing medical care to one of the most deserving segments of our population.

In the latest Joint Commission on Accreditation of Health Care Organizations survey, the Grand Junction VA Medical Center received full accreditation with commendation in both hospital and long-term care programs. This is the highest award given by the organization. Commendation is granted only to the top 2 to 5 percent of all health care facilities in the United States. We are convinced that our ambulatory care program played a significant role in our receiving that award.

I thank you, sir, for allowing me to present this.

[The prepared statement of Dr. Rhyne appears at p. 45.]

Mr. EVANS. Thank you, doctor. Mr. Ayres.

STATEMENT OF THOMAS L. AYRES

Mr. AYRES. Thank you, Mr. Chairman, for the opportunity to be here.

As you know, VA medical centers, in spite of all the new technology and all the wonderful changes that have taken place with the education and training of physicians, have but one job, and that is to take care of patients, and we at the Augusta VA Medical Center believe that our patient rep program epitomizes this dedication to veterans and to patients.

If you will indulge me reading the testimony, it might invoke some questions later on that you may wish to come back to.

First of all, with your permission, I would like to introduce the patient rep supervisor I hired away from Louisville, KY, about 4 years to head up the five-member patient rep program. Harold Wells is on the front row there and is the team leader, and he is a fine representative of the VA and a man that is dedicated to patient care.

VA Medical Center in Augusta is a two division 1,033-bed, complexity level one, medical center. The downtown division is a 380-bed acute medical and surgical facility including a 60-bed spinal cord injury unit. The uptown division is a new 653-bed psychiatric, intermediate medicine and rehabilitation facility which includes a 60-bed nursing home. The VA Medical Center in Augusta is located on the Savannah River, and 30 percent of our veterans are South Carolinians. We have a staff of 2,300 employees; we have a budget of approximately $134 million.

I was appointed to directorship in Augusta in June 1990. I felt there was a need for a direct channel of communication between medical center management and our patients, their families and other consumer groups. Based on my previous experience in Salisbury, NC, with patient rep programs, I felt very strongly the need to implement this type of proactive program in Augusta.

We have five patient reps in this program, and their hours are based and developed on the needs of the patients and their families with reference to when they visit and to provide coverage on the weekends. They are scheduled so that access to patient reps is user friendly.

The concerns of the veterans and their families with the tribal language problems in a hospital, where we speak in foreign tongues of EKG's and CAT scans and so forth, is terrifying to most of us who have not spent half their lives in hospitals. The patient reps go a long way in reducing the fear and also the embarrassment that many people have in asking for directions. No one wants to embarrass themselves by admitting they might not know what a CAT scan is or what goes along with it.

Our patient reps were selected based upon their abilities to communicate and their compassion to understand the needs of the patients. They come from social work associate ranks, they come out of nursing, they come out of medical administration, they represent a cross section of interests, and they, too, can work between each other to provide the expertise that one or the other may not have.

We believe the major benefits for the patients are as follows: Improving the quality of care by better communication, problem resolution and reporting, and cost effectiveness through appropriate utilization of time by our staff. If we didn't have a patient rep program, you might imagine the interaction and the time wasted with the chief of surgery meeting with patients who really have medical problems or orthopedic problems, but not specifically surgical problems, and these unfortunate situations have been greatly reduced.

Our contacts have been reduced in the director's office by some 400 contacts in the last 2 years and everywhere I go in Georgia and South Carolina, praise has been heaped on me not as medical center director nor any of my executive staff, but, "You have got the most wonderful patient reps, Mr. Ayres, that we have ever encountered." This is what Mr. Gober has alluded to frequently. This is when you know you are getting it right.

I could go on and read from this testimony, but I would like to make one suggestion to this august group and to the people here in the audience to visit a VA hospital. I know all of you receive letters of complaint, concerns or praise, but we would like to have Members of Congress visit, we would also like to have the public visit, and especially the service organizations.

In conclusion, we took Mr. Gober and Mr. Brown's suggestion for "Putting Veterans First" very seriously at Augusta. We solicited the concerns of our 2,300 employees to determine how we could provide better services to our veterans. I have 250 recommendations to deal with, and, what one would suspect in those suggestions is griping, complaining, and grousing about things. I'll tell you, it was the most refreshing experience with a survey that I have ever encountered.

Based upon these recommendations, I have requested from VACO two 800 telephone numbers so that the patients do not have to invest their limited incomes on long-distance calls that can frequently be misrouted, put on hold, or this type of thing.

One other suggestion which I thought was just incredible was to develop, through our phone system, the capability for patients to have direct access to the director through a telephone answering system which I, in turn, review each and every morning. One would suspect that I would want to spend hours reviewing these calls.

The questions that are coming in in the early stages of this implementation are very direct, and many times the patient reps can respond to them. It also gives me hands on information about appointment times, clinic times, and it gives me the opportunity, with the chief of staff and/or management officials, to go right to the source. The recording is anonymous which a lot of people feel more comfortable about.

We take patient care and putting veterans first very, very seriously at our place and it is an all employee buy-in. The "Putting Veterans First" committee is a standing committee. They report to me. Other management officials now, as part of their performance for the next year, will participate actively in the implementation of these recommendations.

So again, I thank you for the opportunity to come and I would hope that I can answer any questions that you might have. But if I could again make one plea or one suggestion, you don't have to visit my hospital and we would love to have you, but visit a VA hospital. It puts you in touch with your constituents as well.

It is like preaching to the choir in a sense, but you will have firsthand knowledge of the dedication that exists in the VA, and, again, as Mr. Gober alluded, we have had our light hidden under a bushel for too long a period of time and I can't explain why.

But, again, thank you very much for the opportunity to be here today.

[The prepared statement of Mr. Ayres appears at p. 55.]

Mr. EVANS. Thank you, Mr. Ayres. I want you to know that I recently visisted the VA hospital in Portland, OR and it is a pleasure to now recognize the directof of that hospital, Barry Bell.

STATEMENT OF BARRY L. BELL

Mr. BELL. I was just going to say Tom, Lane Evans was at the hospital 3 weeks ago in Portland, OR.

Good morning and thank you for the opportunity to speak to you about some of our innovative programs.

In the written testimony that I have submitted to you I have outlined 15 programs. What I would like to do now is quickly highlight 10 of them. They are grouped into three areas. The first of these are innovations to improve patient access and coordination of care.

Our telephone care program is a good example of meeting patient needs as quickly and efficiently as possible. Before our telephone care program was established, patients' accessed nonemergent care and many times administrative services by walking into our emergency care unit. Unscheduled workload caused long waiting lines

and lost efficiency while jeopardizing our ability to provide emergent care to those most in need.

Using telephone care, patients get quick answers to eligibility and administrative questions, talk to an advice nurse, a pharmacist, or a patient representative, or schedule a nonacute appointment in our primary care evaluation clinic.

Since the beginning of the telephone care program, emergency care unit visits have dropped over 19 percent while telephone care's clinical calls have increased by 211 percent, and the total calls received last year were 53,000. Our telephone care unit is now looked at as a model for the VA.

Another program which directly improves patient access and ensures a more appropriate level of care is our short stay care unit. This unit provides for patients who have previously been admitted overnight for procedures such as blood transfusions, G.I. procedures, day surgeries, IV antibiotics, but now receive their care as outpatients. The short stay care unit has significantly contributed to an overall 22 percent reduction in inpatient discharges while caring for the same number of veterans by shifting this workload to the outpatient area, a more appropriate setting.

We have created a multidisciplinary breast clinic to provide a medically and economically effective outpatient clinic specifically focused on breast diseases and conditions of women. Women receive same day test results on their conditions immediately followed by a consultation with the appropriate specialist to answer questions and provide immediate support.

We have developed three programs to deal with patients who were considered to be either difficult, dangerous, or to be drug seeking. Each program helps assure better care for those patients whose behaviors complicate the doctor's goal of maintaining health and minimizing the effects of chronic diseases.

Through the 3D program we have documented a 90 percent reduction in violence in our medical center while still providing care to patients considered dangerous who formerly would have been excluded from care because of their violent behavior. We have achieved a 50 percent reduction in emergency room visits by patients considered difficult who have been referred to our coordinated care review board, and although there are no statistics available, our management of patients attempting to receive narcotics through multiple means has been significantly reduced.

The second area that I want to talk about are programs which enhance overall care while addressing special needs. We have built two patient lodging units which allow convenient lodging options for patients and their families from out of town. These lodging units are for patients who receive specialty services such as liver transplantation or radiation treatment and who must stay in Portland during an extended treatment period.

We created an orthopedic teaching video which prepares patients who are scheduled for orthopedic surgery for the many postoperative domestic changes they will face. The videotape program meets the needs of patients who live in remote areas and who find it difficult to attend important preoperative classes. This video was so successful that we are under way producing additional videotapes for other critical preoperative instructions.

Our Northwest Indian Veterans Advisory Council, was created in 1990 in response to the special needs of the underserved Native Americans in the northwest. As a result we have opened a Northwest Outreach Veterans Indian Outreach Office which supports a client base of over 500 Indian veterans who now come to see us. We have coordinated with Native American spiritual healers to work with our chaplain service and are appointing a patient assistant to American Indian veterans which was jointly funded with the Indian Health Service.

Another partnership program is our Vets Express Transportation Program created between the VA and local veterans service organizations to improve access to health care to both disabled veterans and other veterans from rural areas. Vets Express transports patients each day along with medical records, equipment, and supplies, logging over 355 miles daily and saving $7,500 monthly in beneficiary costs.

Lastly, I want to talk about just administration improvements that have freed up significant resources to allow us to then plow those back into helping veterans. A good example of this is our Total Supply Support Program which relieves clinical staff of the time-consuming administrative function of maintaining their own inventory of medical and surgical supplies, which I might add it is not something that clinicians like to do very much.

Our Acquisition and Material Management Service has used the latest in inventory management technology to reduce annual inventory in clinical areas by $475,000 and to improve our fill rate to over 95 percent. That money then was plowed back into giving more care to veterans.

Lastly, the Portland VA Medical Center was the first in the country to decentralize personnel dollars and abolish the FTE requirements for all of our services. This has allowed greater flexibility to services to allocate funds where they were needed most. Unlike the old FTE budgeting system where managers did not differentiate the financial impact of a GS-3 versus a GS-11 employee on their personnel budget because both are considered one FTE, this program makes managers responsible for matching the most appropriate skill level to the position and for managing their total personnel dollars. The thousands of dollars that have been saved doing this have been plowed back into giving additional care.

That concludes my remarks, Mr. Chairman. Thank you. If there are any questions I would be more than happy to answer them.

[The prepared statement of Mr. Bell, with attachments, appears at p. 57.]

Mr. EVANS. Thank you very much.

I want to thank all of you, and I salute you for the innovative things that you are doing at your local facilities. It is very encouraging to hear your testimony today.

Dr. Rhyne, I know that the outpatient clinic primary care model you pioneered is now being spread across the Nation and is being used in clinics that serve so many veterans from my district in Illinois.

When I talk to veterans about the need for change, hopefully, through health care reform, we will obtain money to actually create new outpatient clinics, a lot of veterans still have the notion of an

outpatient clinic having long waiting lines, not having continuity of care and receiving care from a different individual whenever they come in. How did you change that perception? Did it happen just through implementing this program and educating veterans or otherwise?

Dr. RHYNE. Well, again just the change itself, just the feeling of a veterans that, "I have someone that I can call," that we tried very hard to become customer friendly, and many of our people are in remote mountain areas, they are not just, "Well, come on in," and we have networked with our sister hospital in the area, worked very hard with our other two VA hospitals. Although very remote, there are some emergent issues that we needed to discuss.

But primarily we spent a lot of time with service organizations, we spent a lot of time with our employees and basically tried to give the imagine that, "This is your hospital, it is not our hospital." In other words, that is a veterans hospital, that is why it is named Veterans Hospital.

So we have tried to instill into them that you, as a veteran, should have some control as to how you want this place to operate, and we met a lot of times with service organizations, with volunteers, reserve officers. We did a lot of community activity, and, believe it or not, our best focus now is our current veteran population. Every time there is some type of adverse situation in the community or with the press or that may not be valid, you know, who handles that for us? Other veterans, they arbitrarily go do that, we don't have to go out, because they are very proud of that.

So I think it is a culture that has developed primarily because of the comfort level that the veterans feel. I would say nine out of ten letters that I receive from veterans are complimentary, and it is interesting, they are not complimentary of nursing service or medical services, "Dr. Finnigan, Nurse Mary"—very personal.

It takes time, but you have to have a culture going, and I don't know how—we believe lucky, it evolved, but I think basically they got a sense of comfort that, "I've got somebody I can go to, my wife can call, my sister can call;" if they can't get the doctor, they can get the nurse, the social worker, someone.

I don't know whether that has answered your question.

Mr. EVANS. You did very well. I think by word of mouth, probably by veterans themselves with other veterans, is very important, probably one of the keys. It is something that we really need to publicize more in the new clinics that may be developed so that veterans throughout our country have a different perception of what we actually are doing, not just the perception, but view the reality of what we are trying to accomplish.

You said that outpatient drop-ins or walk-ins were reduced to about 11 percent. Do you anticipate that might be reduced further as you more fully get the word out into the community?

Dr. RHYNE. I would hope so. There are still a significant number that just want to use the drop-in, and after they are triaged, which they are triaged immediately, they are slowing learning that it is better to have an appointment because some of them are still used to it, and they really take a last priority for that particular day unless there is an emergent situation, and they are beginning to do it. So I really think so.

We have updated our phone systems, and we are working on some things, a one-stop service. We are trying to implement the business office concept where you are not running all over the hospital to get your admission papers here, your lab here; in other words, get it all out of the way so they get it one place. We are trying to be a little bit more like the private sector model, although I think there are some problems with that too.

I anticipate it would drop, yes, sir.

Mr. EVANS. Congratulations on your accreditation with commendation.

Barry, what facilities has Portland used to provide its patient lodging units, and how much has it cost to establish this very worthwhile program?

Mr. BELL. We took two old buildings that we had and we renovated those buildings into multiple small apartment complexes. We have one in Portland and one in our extended care division in Vancouver. We have 10 beds in Portland, they are two in a room, and those two beds can be used for a veteran and spouse or veteran and other care giver, a daughter, son, if necessary.

In Vancouver we took one of our old barracks buildings and renovated it for transplant patients. It has not cost us a lot to do that. It has actually saved a lot of money because we were sending those patients who were in need of housing to nursing homes who really didn't need to be in nursing homes. We were sending them to community nursing homes and paying $100 a day for nursing home care because they had to be lodged somewhere, and didn't need hospital care. It actually has saved the Government, and taxpayers significant dollars. Our veterans like it much, much better, not being in the setting where they don't need to be, and they can be with a loved one. This is particularly so for a liver transplant patient when they might have to be in town for 3 months, they can be with a loved one. So it has not cost a whole lot to do it. It has been a small amount of general maintenance dollars and minimal renovation money.

Mr. EVANS. I want to salute you for your outreach to the northwest Indian veterans. What reaction have you received regarding the VA in terms of bringing the spiritual healers?

Mr. BELL. My chaplain—chief of chaplain service, who you might feel would be concerned about that, and some of our other staff have really embraced it.

We have held for 2 years in a row during the summer a 4-day program in which we brought care givers to the Indian reservation and worked with the Indian elders and leaders on Indian issues so they are more sensitive to what are the cultural issues that American Indian veterans have, and so when we then ask the care givers to participate with the spiritual healers, they fully understood the reason why and have embraced that.

Mr. EVANS. That surely shows a great respect for Indian culture, and I think that is one way to encourage more veterans to come into the VA system.

Mr. BELL. We now have, as I said, over 500 Indian veterans who are now seeking care through us who in the past have just shied away from VA services.

Mr. EVANS. I would appreciate being contacted before the next outreach effort, perhaps next year, so I could participate.

Mr. BELL. We actually had one scheduled for August, this month, and it has just been canceled because of the fires that have just ravaged that Indian reservation.

Mr. EVANS. Well, hopefully this outreach program will be resumed in the future.

Mr. BELL. We would be happy to invite you at the next one.

Mr. EVANS. Thank you.

Tom, your written statement refers to incorporating the veterans' viewpoint in the policy-making process ensuring veterans are aware of the opportunities at the VA medical centers and evaluating programs to ensure the needs of veterans—that the needs of veterans are being met. In addition to the patient representative program, how are these goals being accomplished at the Augusta Medical Center?

Mr. AYRES. I was just chatting with the VFW guest here about a new initiative that we are getting ready to put on the street. We feel that we are similar to all organizations where communication must flow up and down, whether it be Vietnam Veterans or VFW or even local churches. Often good communications get blocked. So we have decided to take our show on the road. We are filming at local American Legion, VFW, and DAV posts to demonstrate what is going on in the VA and using the people in the posts as part of our program. We then use a mailing list that we have for Georgia and South Carolina to introduce this tape to our veterans to demonstrate to them what is taking place at the medical center in Augusta. This also affords me an opportunity as Lead Director, to describe what is going on with health care reform. I want to ensure that veterans are included, not excluded, in any State health care plan that comes about. We feel that this marketing tool will reach the grassroots level and give us feedback for our patient rep program and for other reporting purposes.

All of us in our Medical Center have service organization, NSO, or SO's in our place. They are all part of putting veterans first. I have monthly or quarterly meetings, depending upon the availability of representatives, to discuss what is transpiring. We utilize any communication outlet we have, and then circulate through the waiting areas to inform and listen to our patients. It is very important for the patient reps and myself to be visible. It is not unusual for the director or chief of staff to sit down and talk to people in the waiting room and learn their concerns and then incorporate them and do something with them.

This is the way that we are trying to better position ourselves for what ultimately will come with health care reform. I think if nothing else ever comes from health care change reform, the threat of health care change has made a measurable difference both in the private sector and in Government on how people are treated. It is a sad commentary that it takes that kind of action, a Pearl Harbor, so to speak, of health care, to force industry change. I think it has been great in that sense. We are getting back to what we are there for and that is taking care of our veterans.

Mr. EVANS. How can individual facility innovations which improve services to veterans be better publicized and adopted by other VAMC's?

Mr. AYRES. Any particular order?

Mr. EVANS. It doesn't matter.

Mr. BELL. The western region for a while was publishing an innovation newsletter last year. As the region's staff decreased with the thought that we would be going into VSA's, they have stopped publishing that letter. The newsletter was very good. I think it came out three times, and any medical center could submit programs such as what I have talked about today.

There would be a write-up of the program which listed a contact person. We got a lot of contacts, particularly on our article on the telephone care unit, from other VA medical centers who read about that and called us.

So I think a general newsletter that is published by the VA and allows VA medical centers to submit articles about new and different things would be useful. I personally enjoy receiving newsletters such as those as well as taking all the testimony here today because I am sure there are a number of things here that I will learn about for my medical center. In summary, sharing through a newsletter I think is a very, very good way of doing it.

Mr. EVANS. Tom.

Mr. AYRES. We do not have a national VA newsletter to cover these type of things. I think we are now posturing to see what the reorganization is going to be. Based upon some of the recommendations then, if we go to VSA's or go to mini regions, or whatever, we need this vital communication link.

We also have video capability now in all medical centers but we just are not in position to share information between 171 hospitals. You see me busy taking notes here about various communication systems and I am going to find out more about that before he gets out of town.

But it is a definite need in our system. There are probably 171 different recommendations out there on how to implement it. But it is long overdue, long overdue.

Mr. EVANS. Doctor.

Dr. RHYNE. Yes, I would agree with them that there is no internal national newsletter on innovations. What we have attempted to do is sort of go the extramural route. In other words, success always seems to heighten a little bit if somebody else is tooting your horn, and so we have made a special effort over the last 2 years to have joint meetings with—not joint meetings, all the national adjutants and commanders of the major service organizations, plus we also have a quarterly meeting with all the staffers of our congressional delegation, and at our last meeting we decided that we would jointly have this between the State commanders of the service organizations, the VA officials, and the congressional staffers or the congressional members if they would like to come.

Surprisingly, this idea, which doesn't sound very innovative, has really created a little bit of interest, and the reason we did this is basically to alert these people of things that might be coming down from within the agency. I think this is the same communication thing, not only things that are good, but when you read the tea

leaves, the same things that may be bad, we would like to get it up front right away to help them answer questions and get rid of this conflict.

So I think what we have done—and I am sure the reason I am here today is because somebody recognized, whether it be a veterans organization, has recognized this and CO, but we don't have a mechanism, and I at this point don't know how to do it.

Mr. EVANS. It seems VA could do better in facilitating and publicizing innovations. Do you have any specific recommendations in addition to a possible newsletter?

Mr. AYRES. I would think perhaps we could take a look at *U.S. Medicine* and the format in which *U.S. Medicine* is published and maybe develop our own VA newspaper patterned on something like this. We are certainly a large organization in health care and we have the expertise, I believe, both at the local and national level.

You know, we are featured quite often in *U.S. Medicine*, and I am waiting with some anticipation today to review an article about our DOD relationship in Augusta Eisenhower Army Medical Center. But I would suggest that could be looked at as an opportunity.

Mr. EVANS. How about E-mail? I know that the VA has its own computer system. I don't normally use the computer to communicate with my colleagues, but maybe it is something the VA and Members of Congress ought to consider.

Mr. AYRES. I am user unfriendly in that category. I am a people person and hands-on type. I get enough E-mail internally, and I kind of look on E-mail as avoidance of eye-to-eye or face-to-face decisionmaking. But I think our E-mail system is overused, perhaps not for good things, just a lot of clutter.

Dr. RHYNE. I think there should be some encouragement to do it, and once that happens the internal mechanism—and I don't mean that it has been discouraged, I think it is just to put an emphasis that we would like to share this from our officials in whatever mechanism. I think it is just one of those things that we assume and it is good, and then word of mouth takes a hold and there is no formal, "We need to do this, we need to share this," and let them help us to devise it.

Mr. BELL. I think the E-mail system is good for follow-up after people are aware of the substance of the program. It is a much more informal kind of system, and you are not sure exactly who is reading—who is getting it.

When I talked about the newsletter, I think that is a more formal system that works well because we can all see it and it can be published on a regular basis. The medical center will take the time then to develop a write-up that is self-explanatory, and those medical centers that see that as something that could be useful to them would be able to use it. Also, when I see those it generates in my own mind and in my staff's mind, "Well, gee, we have a program that is somewhat different but also would work well, let's publish it."

So I think it is a simple way. I don't think it would cost a lot to do that and would be a relatively easy way of sharing innovative ideas.

Mr. EVANS. Does minority counsel have any questions?

Ms. DONOHUE. Thank you, Mr. Chairman.

Dr. Rhyne, Mr. Ayres, Mr. Bell, would it be fair to say that your programs reflect to some degree the HMO concept of emphasizing preventive medical care as a means of reducing both costs and hospitalization?

Dr. RHYNE. Well, as I mentioned in my testimony, we have developed a rather intensive patient education program by the teams working with those patients, so to fully equate it to an HMO I would hesitate to do that, but prevention certainly is—and, again, I think that is shown in the number of hospital admissions, the number of acute cases that come in, plus the ability to get consultation over a phone I think is certainly all part of that aura of preventive health care. I really think yes, it has.

Mr. AYRES. I agree. We have a rather unique model. Being familiar with Minnesota HMO's in Minneapolis and some failed HMO's in North Carolina, I believe that our emphasis in recent years on outpatient care in the VA with our sustained support of inpatient services is, in a sense a form of managed care. When you look at the VA system, from my perspective, we are 171 different franchises, so to speak, and we have so many differences in our regions of the country—Midwest, Southeast, Northwest—that the cultures are different, and so our hospitals can't be lumped any more into a "one size fits all" system.

We have four or five new chairs at the Medical College of Georgia which is part of our alliance with Eisenhower Army Medical Center and the VA, and we are looking at how we can use telemedicine, which I think most of you have heard about. This is a unique program in Georgia and we will do just what you are suggesting. We will have an interconnective telemedicine link between the VAMC in Autusta, the Medical College of Georgia and the VAMC in Dublin, GA, which is 70 miles away.

It would take longer than we have for me to explain this concept, but I would be happy to send you more information. But it is "state of the art" in medicine for the future. It takes it beyond an HMO because it puts a specialist at the fingertips of the local physician.

Mr. BELL. From the patient's point of view, an HMO really has two things. One, it has a consistent point of contact with a provider, and then that provider decides what are the real needs and where should that patient be sent within the system to get the care that they need. That has not always been the way the VA has operated. We have not always done that. I think most of us or many of us have taken those two basic elements of the HMO model and are trying to install it. That is what Bob talked about when he talked about his firm which is having a provider group that is responsible for an individual patient, and that patient knows that.

So I think yes, we are moving toward those elements of HMO. There are other aspects of HMO which I am not sure, being a Government agency, that we can do quite as easily, but certainly making sure that every patient has a provider and that that provider oversees all of care of that patient is a model that I think all of us are moving toward.

Ms. DONOHUE. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. I want to thank you all. Mr. Ayres, 2 weeks ago we did hold a hearing on telemedicine and we are very familiar with

what is occurring in Georgia. We heard from Dr. Sanders and appreciate your leadership in that area as well.

I want to salute you all. You represent the smallest to the biggest VA facilities and we really are encouraged by the work that you are doing.

Thank you very much for testifying today.

Mr. EVANS. The members of our next witness panel are Barbara Zicafoose, Jim Bradford, and Karen Walenga, who will be represented by Jean Swenson this morning.

Barbara is a Female Veterans Coordinator and Women's Health Clinic Coordinator at the Salem, VA, VA Medical Center, and it is good to welcome her before the committee again today.

Jim is a Vocational Rehabilitation Therapist at the VA Medical Center in Long Beach, CA.

Due to a serious illness in her family, Karen is unable to testify today. In her place we are happy to welcome her colleague, Jean Swenson, who will present Karen's testimony. Jean is Nurse Manager, Nursing Home Care Unit One.

Each prepared statement will be included in the printed hearing record without objection. Without objection, the prepared statement of the gentleman from Illinois, Mr. Gutierrez, will also be included in the record of this hearing.

[The prepared statement of Congressman Gutierrez appears at p. 40.]

Mr. EVANS. Barbara, if you would like to proceed we would recognize you first.

STATEMENTS OF BARBARA ZICAFOOSE, MSN RNCS NAP, ADULT NURSE PRACTITIONER/FEMALE VETERAN CO-COORDINATOR, WOMEN'S HEALTH CLINIC COORDINATOR, VA MEDICAL CENTER, SALEM, VA; JEAN SWENSON, NURSE MANAGER, NURSING HOME CARE UNIT ONE, VA MEDICAL CENTER, PHOENIX, AZ; AND JIM BRADFORD, VOCATIONAL REHABILITATION THERAPIST, VA MEDICAL CENTER, LONG BEACH, CA

STATEMENT OF BARBARA ZICAFOOSE

Ms. ZICAFOOSE. Chairman Evans and members of the subcommittee, I am pleased to be here today to present information on the women's health care clinic, the day unit, and the primary care clinics initiations which have improved care to veterans at the Salem VA Medical Center. I am a nurse practitioner assigned to the day unit and have been employed at the VA for 22½ years.

Health care delivery at the Salem VAMC has undergone significant changes since 1991. One notable change has been the establishment of a women's preventive health clinic to provide gender specific care. Physical space, equipment, and consumer focused needs were major resource issues.

We decided to use one private patient room in the newly established day unit as the women's health clinic with staff support from the day unit. The room is assigned to the clinic two days per week and the remainder of the time supports other outpatient services. The women's health clinic is managed by nurses in advanced practice with physician liaison. The clinic provides a specialized and

comprehensive program to assess, treat, and/or refer female veterans for such illnesses as oral, breast, cervical and colorectal cancer, hypertension, diabetes, osteoporosis, and identification of risk factors such as elevated cholesterol.

Other services available include hormone replacement therapy, information on and treatment of sexually transmitted diseases, and education and counseling for sexual and physical abuse, menopause, breast self-exam, aging, sexuality, smoking cessation, nutrition, diet counseling, and exercise. Education regarding life-style changes is an important component of the program.

Through 100 percent follow-up of quality improvement and patient satisfaction surveys, we provide continuity and quality care and improve services to our patients.

An outgrowth of our women's health clinic has been a primary care team for women. While the women's health clinic provides preventive screening, the primary care team for women provides comprehensive, managed care of acute and chronic medical problems.

Two and a half years ago Salem initiated a unique delivery of care model called the day unit. The unit is an outpatient ambulatory care clinic offering services to surgical, medical, and psychiatric patients in a cost-effective manner. These services include ambulatory surgery, diagnostic medical procedures and work-up, risk stratification for surgical patients, monitored cardiac catheterization recovery, emergency consultation, patient family education, and preventive health services. Seventy-three percent of all Salem's surgeries are currently performed through the day unit on an outpatient or same day surgery basis.

Management costs for labile diabetic patients have been reduced by 60 percent since initiation of the outpatient treatment in the day unit as a opposed to admission to the hospital.

Transcending the traditional hospital philosophy which encourages inpatient versus outpatient access, Salem's day unit provides a creative, comprehensive approach to patient care. It allows consistent care by the primary care providers using advanced practice nurses as part of the team. The model also provides a setting for focused research and education.

The flexibility of the unit allows for the development and initiation of clinics managed by advanced practice nurses; for example, the women's health clinic and derminal wound clinic.

In 1991 a restructuring of the ambulatory care clinics into primary care teams occurred. The essence of our primary care teams is to provide optimal functioning for each patient on an ongoing basis within a managed care system. The ambulatory care staff were divided into teams using the interdisciplinary team approach to patient care. Each patient was assigned to a specific team. Now the patient's health care experience is managed by his or her primary care provider.

The team provides initial and continuous evaluation, risk stratification, education, ongoing follow-up, counseling, references, and an array of other specialty services. In addition, the team members follow their patients during each hospital admission with care resumed by the team upon discharge. Thus, patients receive consistent care by the same primary care provider each time that care is required.

Primary care teams include a physician, an advanced practice nurse or a physician's assistant, senior nurse clinician, and a medical assistant. A social worker, MAS clerk, psychologist, and pharmacist are available in each area and are shared by various teams.

Decisions made within each team are interdisciplinary, patient centered, and outcome oriented. The matrix management model for program development and enhancement as well as staff involvement in decisionmaking is utilized in this primary managed care model.

The concept of primary care teams and ambulatory care clinics has resulted in favorable outcomes for patients and staff. There is a commitment to provide appropriate, timely, and cost-effective quality care. A special bond exists between patient and provider, something not easily recognized before primary care teams. The patients get to know their team members well and consider them "my nurse," "my doctor," "my nurse practitioner." Reciprocally, the staff have a specific patient case load which they become familiar with. The result is continuity of care for the veteran, improved communication within each team, and increased accountability of staff on the primary care team.

With this primary care delivery model, fragmentation of care has become nonexistent. The average case load for each primary care team currently is approximately 1,500 veterans per month. This number is consistent with those seen in HMO's; for example, the Harvard community HMO.

Other innovative programs have recently been or will be initiated this year at Salem. In October 1993, a non-service-connected primary care clinic for pensioned, low income, or homeless veterans was implemented. In May of 1994 the medical/surgical subspecialty clinics were restructured with the team format patterned after primary care. Psychiatric primary care teams have recently been implemented, and a preventive health care and improvement clinic will be open in September. All of these programs were developed within current budget constraints and shifting of existing resources from inpatient to outpatient areas.

Staff selections for these outpatient programs were based upon clinical experience, high levels of competency, previously demonstrated creativity, and ability to work collaboratively with others.

Since 1991 the Salem VAMC has initiated several programs which have impacted on care and available services to veterans. The women's health clinic, the day unit and primary care teams all use an interdisciplinary approach to provide comprehensive managed care to patients in varied settings. Ongoing screening, counseling, and education are provided in an accessible, coordinated, and sensitive manner. With members of the interdisciplinary team working together with the veteran as partners in managed care, disease prevention, and health maintenance, we are affording veterans for a longer, healthier future.

Thank you.

[The prepared statement of Ms. Zicafoose appears at p. 81.]

Mr. EVANS. Thank you, Barbara. Jean.

STATEMENT OF JEAN SWENSON

Ms. SWENSON. Mr. Chairman, thank you very much for allowing me the opportunity to appear before you today.

In the spring of 1989 the 120-bed nursing home care unit of the Veterans Medical Center in Phoenix, AZ, experienced an acute rise in patients requiring total nursing care. Along with multiple other functional losses, 25 percent of the population required total feeding, with another 50 percent needing tray preparation and encouragement to self-feed. Managerial attempts to handle the increased demand through the staggering of tray delivery times, alteration of work schedules to concentrate staff at meal times, and attempts to recruit individuals through volunteer service brought insufficient relief.

Due to time constraints and the number of patients, it was distressing to note that the staff began grouping patients and hurrying between them with little social interaction. Functionally impaired but otherwise cognitively intact patients were acutely aware of the dilemma and felt a need to hurry at meal time. The obvious solution of more staff was not possible due to the reality of fiscal constraints.

The idea for the Breakfast Club was born one hectic noon meal in June of 1989 when the supervisor for the nursing home care unit found herself simultaneously resolving a priority issue with an employee from another department while assisting patients with meal setups and feeding. While engaged in conversation and fueled by the frustration of the moment, she spontaneously asked the individual to pick up a spoon and help the patient next to him.

His response sparked an idea. He was very hesitant at first. He picked up the spoon, and then he stated, "I had no idea that you needed this kind of help. It really isn't so hard to do. Maybe I could come and help again another time." This idea, why not ask medical center employees to volunteer some time before work or after work to help feed nursing home patients? Caring, motivated people exist in every organization, especially health care facilities. Could we tap into this resource and encourage volunteers to volunteer—encourage employees to volunteer on site? The answer was yes. Growing from a small nucleus of 11 employees to 90 within the first year.

The phenomenal response to the program was attributed to the following actions taken prior to and during the initiation of the program. Top management support was gained through explanation of need and commitment of volunteer service of medical media support. Also included was personal involvement of the medical center director and chief of staff in the feeding program. Publicity was obtained. We got the word out to employees through word of mouth and also through medical media brochures. We adopted a Breakfast Club logo. We put out fliers, we had posters, we had badges, and we also used the in-hospital TV program to recruit participants. We also started small. Volunteers were asked serve one hour once a month and to please come and feed.

The recruited volunteer coordinator was most likely the greatest asset to the success of the program. We recruited a volunteer who knew the patients, the staff, and the other volunteers. Her position consisted of facilitating schedules, facilitating personal preferences, and she also provided positive feedback to the participants. She

also maintained open lines of communication between nursing staff and volunteer services. The nursing services welcomed this support with open arms, with verbalized appreciation continually with volunteers.

Also, flexibility in the program was encouraged. We opened the program up to suggestions. Some individuals felt that they were not able to feed patients. They helped by preparing trays and also by socializing. They also brought other talents. We had volunteers who cut hair, who walked residents, who started a gardening program just through developing interest in the nursing home care unit.

Finally, we did recognize these volunteer employees. We provided buttons with the Breakfast Club logo. Medical center employee awareness was fostered through pictures and personal accounts in the medical center newsletter. The publicity and top management personnel commitment led to interest and curiosity from many of the service organizations. Discussion with these organizations resulted in them providing hands-on help at the noon and evening meal where employee volunteerism was low. As a result, we had two more programs which were started—"Let's Do Lunch" and "Guess Who's Coming To Dinner?"

Costs have been minimal in comparison to the benefits. We purchased lapel buttons and an annual recognition ceremony. Those were the only monetary costs.

Patients in the nursing home care unit reaped multiple social and quality of life benefits. Their otherwise closed community has opened up to a variety of volunteers who provide friendship, caring, and a tie to the outside community. For the patients, mealtime becomes special with increased socialization and also increased food intake. This was sometimes accompanied by decreased confusion and an increased desire for personal grooming. The mingling of employee and patient in a personal bond increases the patient satisfaction and may result in more inspired, informed work place.

Other VA's have become aware of this program through national telephone hotlines. We have participated in national and local workshops, and we have presented poster presentations. At this time approximately 50 VA's have requested information in order to institute their own volunteer programs. This has had a very positive effect on residents and also on staff, and I can personally attest to that. I was there at the beginning of the program, and it continues very successfully to this day.

(See p. 94.)

Mr. EVANS. Thank you very much. Jim.

STATEMENT OF JIM BRADFORD

Mr. BRADFORD. Good morning.

Mr. Chairman, I am very honored to have the opportunity to address this subcommittee. I am a vocational rehabilitation therapist and registered horticulture therapist at the VA Medical Center in Long Beach, CA. As a horticulture therapist, I have been able to develop an innovative program which has improved available rehabilitation service to our veterans, particularly those who are severely disabled.

Patients that work in our horticulture section are referred from the medical, psychiatric, and homeless programs. Drawing from this pool of patients, I have been able to weave a common bond of learning, assisting, and understanding through the medium of horticulture.

The garden is designed to provide year-round production and work on the two-acre site. Patients work in raised garden beds with wheelchair accessible planters and often in the greenhouse. A large section of our garden has wide cement walks for wheelchair accessibility. Patients are given the opportunity to use many tools that have special adaptive features like one-arm grabbers for patients that can only use one arm or wheelchair patients that can't reach very far from the wheelchair. The long-handled pruners grab, and they will also hold on to flowers and vegetables and that sort of thing.

Severely disabled quadriplegic patients are carefully taught to enjoy their gift in helping in the system by planting the seeds. This is accomplished using a tool that I have made many adaptations to call a bird beak mouth stick. The patient can activate a set of tweezers at the end of a mouth-held piece by using his tongue to press a button and pick up seeds. The seeds are carefully placed by this method into a prepared flat then moved into the greenhouse for propagation. This gives the quadriplegic patient an important role in the overall operation. He starts it all with the seeds.

Utilizing this system, I have seen patients that had very little to look forward to each day begin to cherish each moment they were up and working. They are actually a contributing member of a team in the gardening process.

Our garden area is filled with over 100 trees, lush lawns, and abounding flowers. The large vegetable planting area offers an exceptional source of fresh fruits and vegetables that often become the enticement to spur participation and learning.

The garden area can be a quite peaceful work place for severe psychiatric patients. It also provides a work situation where the more capable veteran can earn money, learn good work skills, and also learn habits that might be future employment goals.

In our flower garden we help local wholesale growers by providing trial beds for new plants. These growers donate flowers to us for us to evaluate the progress of through their future sales. These plants offer an ample source of plant matter to teach patients proper planting techniques. These growers also provide us with plants that are too large for resale but perfect for use in cut flower arrangements.

On a weekly basis, for pay, we provide fresh cut flowers arranged in bud vases for local restaurants. We also get paid to build custom wood pots to sell. These are all accomplished through our compensated work therapy program which is something I have adapted to our horticulture program. This program enables patients to receive pay for helping plant, tend, pick, and sell selected produce and flowers. Crops are sold, and the patients are paid from the proceeds. The main crops in spring and summer are tomatoes and squash. The main crop in the winter is a poinsettia crop grown in our greenhouse and also propagated interior plants.

Patients are taught how to care for the plants from start to finish, learning valuable information for employment in the plant industry and often just for pleasure. Projects such as those mentioned help the patients learn the basic concepts of designing, planting, and maintaining plants. Consequently, there is a double benefit: First, the training of our patients and, second, cost savings to the hospital.

One of my elderly patients summed up the project with this poem. I believe it depicts what I have tried to accomplish.

"Garden.

"Garden deserves our love and praise, where one may sit in peace and gaze at lovely flowers and plants because they charm the eye, please the nose.

"For folks in sorrow, pain, or gloom are cheered by a kingdom that is in bloom, and veterans who live through hell come to the garden to get well.

"Garden reach can feel and see how nature decorates a tree, and every seed in fertile sod becomes a plant, the word of God.

"Blessings and grace come from above when garden work is done with love.

"Garden is Adam's place of birth. There is no better place on earth.".

The author, Nicholas P. Byrd, is an 84-year-old retired naval officer, fellow veteran, former patient, present volunteer. Use of volunteers has been just an incredible extension of our ability to serve patients.

While the main theme of my presentation today has been related to horticulture, there are other services that our department offers. Some of the services are: We developed a hands-on computer training program, major software programs such as Wordperfect, together with the veteran receiving training in each category.

Upon completion, they are enrolled in our job club where they receive an intensive week-long training on job seeking and job survival skills. They learn proper job application techniques, resume preparation, presentation skills, and all these are practiced on video, and they are placed in an incentive therapy position, meaning they are placed in an actual compensated job within the medical center for up to 1 year. Other graduating veterans, 62 percent have become employed within 4 months after the incentive therapy program.

I want to thank you for giving me the opportunity to present these programs to you. I would offer an extension for any of you to come and visit us at Long Beach at any time.

My time is up, but I could talk all day about the benefits of these programs.

Thank you very much.

[The prepared statement of Mr. Bradford appears at p. 99.]

Mr. EVANS. Thank you, Jim.

I want to thank each and every one of you for your personal initiative and leadership on behalf of our veterans. These are very innovative programs at your respective facilities. I think the statistic of 62 percent of the program graduates from the computer program is something we certainly want to highlight. I am not sure I know

of too many vocational education programs of a longer nature that are that effective.

Barbara, I know that the improvements that you are making now in primary care for women are directed to our women veterans. Under national health care reform I understand that, immediately at least, a family would likely opt out for the VA system. Women who are not veterans, but the spouses of those veterans that would use the VA, would receive contract care provided by VA.

I would assume, though, that over a period of time VA would try to bring spouses and the dependents into the VA health care system. What you are doing now is useful not only helping women veterans now, but in bringing women, the spouses of veterans, into VA in the future. Is that your understanding as well?

Ms. ZICAFOOSE. Yes, sir, and I think we are beginning with that initially with CHAMP-VA where we are now seeing spouses of 100 service-connected veterans in some VA's. Our VA is currently writing a proposal to begin that program in the near future, and I see that as the first step of bringing families and spouses particularly into the health care system in the VA.

Mr. EVANS. I wasn't aware of that. I think that is a good way of trying to help out deal with that specific problem as we make that transition, so you are educating me today.

Ms. ZICAFOOSE. Another good effect of the CHAMP-VA is that the local VA that has CHAMP-VA gets to keep the money that they can contract out—you know, they can fee base out. If they can get the money from the insurance company, they get to keep it at the local facility instead of returning it back to Washington. So it does help the local facility.

Mr. EVANS. Jim, how extensively used is therapeutic horticulture being used throughout the VA? It seems like it is a very good program. Is this being used in a lot of other places?

Mr. BRADFORD. Quite a few. My last recollection I had—I had a list of 54 different VA medical centers that had it. But it is a very inexpensive way to treat patients, and there are also large benefits from it that really don't cost the VA but very little, and a lot of the VA hospitals have used these to upgrade a lot of the fronts of the hospitals, you know.

At our VA we take care of the beds in front of the hospital as a patient project. We use all donated flowers. That way, the local growers have a chance to show off their plants, and it has just really been a very neat thing to do. We also take care of a National Monument there, and it just gives the patients a bit of unity within the hospital, and they take a lot of pride in that project.

I guess there are 55 different ones if she is doing a little garden project in Phoenix, so I think it is a neat way to treat patients, and all of them can identify with it, all ages and it really works well.

Mr. EVANS. Jean, the Breakfast Club and the lunch and dinner programs have clearly improved the quality of life for the patients and I think the staff as well, helping with their morale.

Ms. ZICAFOOSE. Yes.

Mr. EVANS. I want to tell you, the publicity for these programs really is first rate. I had the opportunity to review this and some of you must have been trained on Madison Avenue, I take it.

Do you know how much the medical center has actually spent to develop and support the Breakfast Club and the lunch and dinner programs?

Ms. ZICAFOOSE. No, I don't have figures for that. I know that it is minimal. We have a breakfast once a year for the volunteers, and we do serve the breakfast in the nursing home. The volunteers, staff members, do have a regular breakfast bar, and I think that is supported by what the canteen receives, where they donate their time, and they also donate some funds for it.

Mr. EVANS. We think it is really great, what you are doing there. Minority counsel.

Ms. DONOHUE. Thank you, Mr. Chairman.

Barbara, would you give the subcommittee your recommendations for improving services to women veterans throughout the medical system? Specifically, what would your number one recommendation be?

Ms. ZICAFOOSE. As far as care for female veterans?

Ms. DONOHUE. Right.

Ms. ZICAFOOSE. And getting it within each facility? I think the primary emphasis most certainly should be on mammograms, making sure all female veterans have access to mammograms according to the American Cancer Society recommendations or whatever the facility chooses. We like the American Cancer Society recommendations.

Breast cancer is the leading cause of death in women, and it is preventable if detected early, and some facilities I know don't have those services readily available for women. So I think offering gender-specific care but specifically mammograms for women and pap smears on a regular basis.

Does that answer your question?

Ms. DONOHUE. Yes. Thank you.

Thank you, Mr. Chairman.

Mr. EVANS. Again, we want to thank you for your testimony. It is very valuable to us, and we appreciate the innovation you have brought to the veterans hospitals in your areas.

Mr. EVANS. The members of our last panel are John Mullaney, Penny Hust, and Mary Ellen Piche. John is a Medical Equipment Repairer for the Engineering Service of the VA Medical Center in Hines, IL. Penny is the Associate Chief of Nursing Services for Psychiatry at the VA Medical Center in Tuscaloosa, AL. Mary-Ellen is the Continuous Quality Improvement coordinator for the Stratton VA Medical Center in Albany, NY.

Again, the prepared statements submitted by each witness will be included in the printed record of this hearing, without objection. Each witness is again requested to limit his or her oral presentation to 5 minutes and summarize from your prepared text as needed. John, we will start with you once you are ready.

STATEMENTS OF JOHN E. MULLANEY, MEDICAL EQUIPMENT REPAIRER, ENGINEERING SERVICE, VA MEDICAL CENTER, HINES, IL; MARY-ELLEN PICHE, CQI COORDINATOR, STRATTON VA MEDICAL CENTER, ALBANY, NY; AND PENNY G. HUST, ASSOCIATE CHIEF, NURSING SERVICE FOR PSYCHIATRY, VA MEDICAL CENTER, TUSCALOOSA, AL

STATEMENT OF JOHN E. MULLANEY

Mr. MULLANEY. John E. Mullaney, medical equipment repair, Edward Hines, Jr., VA Hospital, environmental systems for disabled hospitalized veterans.

Mr. Chairman and members of the committee, I am pleased to be here to testify before this committee.

In 1985 I began noticing that many of our older spinal cord injury residents were regressing in their ability to turn on and change the channels of their TV sets without assistance from the nursing staff. Many of them were already totally dependent on the staff for all their activities of daily living. This problem was becoming time consuming and very frustrating for both the residents and the staff as well.

I designed and developed a prototype box for use by high quads that could be accessed by blowing into a straw to perform three various functions: Turn on the TV, change the channels, and access the nurse call system. After demonstrating the unit, I was told that the funding for such a project would have to come from the private sector.

The service officer from the Rotary was very receptive of my idea and helped me raise enough money to have the boxes built by a manufacturer that I was able to convince. I provided this manufacturer with the overall technical information that I had formulated along with the prototype that I had built. With this information, he was able to provide a final product for our customers.

A total of 50 units were purchased at a cost of $400 each and were utilized by our veterans in the main hospital during the time that Hines VA Hospital was in the planning stage for the first free-standing residential care facility for our spinal cord injury veterans within the VA system.

After convincing the hospital director of my new idea to incorporate an individual nine-inch color TV on a C arm type bracket for each resident's room, the director agreed that the cost savings in man-hours and the ability of increasing the veteran's self-esteem was worth investing in. Not only would this device save staff time but it would give the completely paralyzed veterans a realization of freedom by enabling them to be in control of selecting various functions on this device.

I have attached a copy of the newspaper article that pictures the units so that the members of the committee could see what the finished product would look like. As you can see, the TV can be moved out of the way for emergency care of the veteran; ergo, cardiac arrest, pulmonary seizures, and so on.

On behalf of the disabled veterans I am honored to serve, I would like to thank the committee for this opportunity to present my testimony and what I believe is an invaluable tool of independence.

Mr. Chairman, this concludes my formal statement. I will be pleased to answer any questions you or the committee may have.

[The prepared statement of Mr. Mullaney, with attached article, appears at p. 103.]

Mr. EVANS. Thank you, sir.

At this time the chair recognizes Mary-Ellen Piche.

STATEMENT OF MARY-ELLEN PICHE

Ms. PICHE. Thank you and good morning. I would like to thank you for the opportunity to talk about our Total Quality Management program and the Samuel S. Stratton VA Medical Center. We refer to it as Continuous Quality Improvement, or CQI.

The Samuel S. Stratton VA Medical Center is a 540-bed tertiary facility that provides comprehensive medical, surgical, psychiatric, neurological, and long-term care serving approximately 190,000 veterans. Primary care outpatient services are provided with a broad range of preventive services, specialty clinics, and emergency room services. We maintain an affiliation with Albany Medical College.

Management and employees at all levels of the organization began approximately 4 years ago to implement a Continuous Quality Improvement model designed to improve customer service and create an environment which supports innovation. Leadership, employee involvement, and teamwork are the hallmarks of our CQI program. Operational elements include cross-functional process improvement teams and an automated employee suggestion program, patient/employee feedback systems, and ongoing assessment and strategic planning activities.

More than 60 cross-functional teams have successfully improved the processes of health care delivery to our veteran patients. Physicians, nurses, and lab technologists together with a ward clerk and a volunteer improve the processes of ordering, procuring, and analyzing sputum specimens resulting in a significant decrease in the rate of unsatisfactory sputum cytology specimens.

A multidisciplinary team developed a clinical pathway for patients undergoing total hip replacement surgery. By designing a coordinated plan for a preoperative assessment and hospital care, and post-discharge follow-up, the team improved patient and staff satisfaction, reduced the in-hospital average length of stay from 14½ to 8½, and improved patient's functional status. Other teams are currently working on clinical pathways for patients with diagnoses of congestive heart failure, head and neck cancers, and pneumonia.

Additional examples of employee and patient teams which have focused on improving and redesigning key clinical and administrative processes include our operating room cancellation team which designed a patient preassessment process thereby reducing the rate of OR procedure cancellations.

Our discharge planning team redesigned the process for providing medications to patients at discharge, significantly reducing the rate of medication errors and improving patient and staff satisfaction.

On our short stay unit a team established a patient follow-up telephone call system to prevent serious complications through

early interventions when patients are discharged from the short stay ward.

Our clozaril treatment team designed a monitoring system to evaluate the efficacy and adverse effects on psychiatric patients receiving clozaril. Mechanisms to provide structure, support, and care during the rehab and recovery phases were implemented.

We had a team that implemented procedures to reduce staff and patient injuries during episodes of psychiatric patient aggressive behavior. The 468 code team designed an assessment process to identify and treat patients at risk for these aggressive behavior outbreaks.

Probably our first self-directed work team was a group of nurses who developed a partners in practice model in the OR. They redesigned the delivery of nursing care in the operating room by eliminating the charge nurse position, providing cross-training opportunities for all staff, and assigning the scheduling responsibility to the staff. Results included an improvement in morale of the nursing staff, a decrease in sick time, and improved satisfaction of their customers, physicians, and patients.

In addition to these and other employee process improvement and redesign teams, several mechanisms are in place to obtain employee and patient input and feedback. We automated our employee suggestion program allowing direct input of suggestions from any computer terminal. It is now among the top 10 most productive suggestion programs in the VA.

Every employee is invited to contribute ideas at the quarterly open forum with top management. A popular graffiti board outside the cafeteria allows employees to share their suggestions and work values formally and more directly with fellow employees. Values identified by our employees as most important for achieving our mission and moving toward our vision include innovation, excellence, teamwork, compassion, and quality.

Our employees created the first patient representative steering committee within the VA to analyze patient feedback and guide patient care policy. The steering committee provides case managers for patients with special needs. Surveys of both internal and external customers are used to identify areas for improvement. All employees are encouraged to attempt to resolve patient concerns at the lowest level possible.

Initiatives to redesign the structural and programmatic components of health care delivery include our Plane Tree Unit. This is a unit where patient and family-centered rehabilitation activities occur in a home-like environment, and it offers a holistic approach to care. Patients and families partner with health care providers in their care. This involvement and setting creates an atmosphere that promotes healing.

Our short stay ward which I mentioned earlier was developed to provide focused services to patients having minor surgeries, invasive diagnostic procedures, and short-term therapies. Results include a decreased length of in-hospital stay and improved patient and family satisfaction.

Our Fisher House was initiated by a single staff psychiatric nurse in our facility. She pursued a donation by the Fisher Foundation, and this house will provide housing for families of hospitalized

patients in a home-like environment. It is currently under construction, and we expect to open in September of this year.

Management and staff have developed strategic and operational plans for deploying CQI throughout the medical center. A self-assessment instrument is used as a tool for measuring progress and identifying strategic direction. Ideas for quality improvement come from a variety of sources including patients, staff volunteers, annual assessments, and quality management data.

A cadre of trainers and facilitators exist to support employee-driven CQI teams and improvement activities. The common goal is to use CQI principles and practices to provide a high level of quality health care and related support services to our Nation's veterans. How do we in the field share our successes and our innovations? An enormous amount of networking does occur so that we can avoid reinventing the wheel. Site visits, conferences, E-mail, and telephone consultations are just some of the mechanisms we use to benchmark in the field.

Thank you.

[The prepared statement of Ms. Piche appears at p. 106.]

Mr. EVANS. Thank you very much. Penny.

STATEMENT OF PENNY G. HUST

Ms. HUST. Thank you, Mr. Chairman, members of the subcommittee, and staff for inviting the Tuscaloosa Department of Veterans Affairs Medical Center to come before you and share our vision, initiatives, and innovations in providing quality health care in partnership with our customers—the veterans, their families, employees, volunteers, and our community.

The health care reform transformation coupled with reinventing Government requires a revolutionary change in leadership style. Our medical center began that transformation in 1989 by embracing the concepts of W. Edwards Deming. Since that time we have been successfully questioning the status quo, challenging and empowering our customers, and creating an atmosphere where self-directed work activities, workplace partnerships, and shared clinical outcomes are the norm.

Our medical center has a primary service area of approximately 245 thousand veterans whose average age is 54. We are a neuropsychiatric, primary medical, and extended care facility serving veterans in the northern part of Alabama and parts of Mississippi with 507 hospital beds and 195 nursing home beds. Many of our specialized programs, units, and clinics have been local initiatives designed in concert with the evolving needs, wants, and opinions of our veteran population.

Our vision is to be the recognized health care leader by delivering the most competent, compassionate service possible to all of our customers, Dr. Deming and other TQI proponents teach us that only the customers can define quality.

As a part of our cultural transformation into TQI, we began to more systematically inquire what our customers want and need. In 1991 we developed a local initiative to survey our top four customer groups: Patients, families, employees, and volunteers. Our initial survey results were published and shared with all employees to

sensitize them to customer satisfaction goals and to empower them to resolve issues at the lowest level possible.

Our primary objective was to improve services and the customers' perception of those services, not cut costs. However, we found that many times improving services can be achieved with the corresponding cost-benefit ratio. We initiated an era of true partnership and teamwork that has made customer satisfaction standards an integral part of our strategic planning and resource allocation process. Our patients asked to receive and benefit from treatment, to be treated with respect, to have the right medications prescribed, and to have their special needs met. Our families asked for periodic progress reports of their veteran's status from a knowledgeable staff member, to be treated with kindness and respect, and to receive education about diagnoses, medications, and prognosis.

By utilizing the TQI process, we have developed over 50 patient care initiatives that have improved customer satisfaction and service delivery by meeting customer requests. Our TQI patient socialization team improved the therapeutic environment on a long-term psychiatric unit. They added 16 additional groups and activities, thereby enhancing patient and staff self-esteem, growth, and self-confidence.

One of the most significant outcomes was initiated by a musically talented nursing assistant who formed a singing group made up of some of our more regressed and assaultive veterans. "The Acts," which is the name of the group, has grown in stature and popularity. They have seen two of their members discharged from the medical center and performed for several local community organizations.

With the national shift to outpatient treatment and the concomitant increase in our outpatient workload, we are responding by utilizing our customer survey results, partnership initiatives, and self-directed work team tenet to initiate primary care models.

The Rainbow One primary care clinic was initiated in February 1994 with the primary care team consisting of a physician, nurse practitioner, licensed practical nurse, and medical clerk, continually available. Veterans report their total health care needs are being met. The business and appointment cards that are available on the table and I am showing you here have the names and phone numbers of the primary care team members. The veterans can keep them in their wallets, purses, or at home to be sure they know who to contact. This is evidence of our personalized patient care delivery model.

To summarize, our health care roles are being transformed as we speak. Improving services to veterans through initiatives and innovations is paramount to our very survival in the context of health care reform and reinventing Government. We at the Tuscaloosa Medical Center are doing this daily. We have created an atmosphere of employee empowerment, customer satisfaction, and self-directed teamwork by continually responding to customer feedback.

The true measure of our worth is found in the unsolicited comments from our veterans and their families about our competent, compassionate care, how invested our employees are in their work, and how interested we are in them as people. Each of us, you as

our elected officials and we as your health care providers, are working together to develop radical new concepts of work place culture, relationships, quality, and customer satisfaction. Together we are forging an organizational mind set that serves as a foundation for empowerment and work redesign. We are proud to be your partners in assuring that two of our most important shared customers, veterans and their families, receive the health care they want, need, and deserve.

Thank you.

[The prepared statement of Ms. Hust appears at p. 112.]

Mr. EVANS. Thank you all very much.

I want to also thank all of you for your commitment to improving veterans services at your local facilities, and, John, you deserve a special thanks, I believe, for your determination and persistence in overcoming a disinterested and unsupportive VA. Many people would have given up at that point. We thank you for not quitting also for your attitude that this is a privilege, as you said, to serve veterans. We very much appreciate your work, particularly in the State of Illinois.

Quality programs, including TQM and CQI, have received much attention. Why are quality programs apparently successful at some VA facilities, but not at others and what factors are most responsible for the success or failure of these programs?

Ms. PICHE. What I found to be some of the key factors in a successful CQI program are primarily leadership, and we see in some other VA's that they are not as successful perhaps because in some cases leadership isn't totally committed, and, beyond a verbal commitment to implementation and giving the resources, it is a personal commitment to live it, breathe it, walk it.

Another key factor is employee involvement and the opportunity for employees to be involved, an atmosphere that promotes risk taking and, as someone stated earlier, making mistakes. That promotes employee involvement, getting out of the box and doing things differently and doing those kinds of things to improve care.

Ms. HUST. I agree, and in our particular facility the leadership was there. Our transformational leaders have included our customers, their families, direct care employees, as well as top and middle level management. Listening to our customers has been the key factor for our particular medical center and then doing something with what they asked us for and involving them in partnerships.

We have had partnerships with our two unions in our medical center for years. Even though this is new nationwide with the VA, we have been doing it for a long time, and with our veterans and their families also. That is the key—empowering the customers to be partners and empowering the direct care employees to make the changes needed. Sometimes that does involve risk.

Mr. EVANS. Has either one of your two facilities been called upon to help another VA facility develop these kinds of quality programs?

Ms. PICHE. Continually. We were the 1993 winners of the Robert Carey Quality Award, and so we had a lot of visibility in terms of our program.

During the past 2 years we have made presentations at national conferences, we have hosted dozens of medical centers, teams from medical centers, on our site to take a look at our program. We do telephone consultations, electronic mail discussions, send out material, so I think that is one example of extensive networking in the VA in terms of the total quality programs.

Ms. HUST. We have done everything she said, plus we are the 1993 Carey Quality Award winners in the Health Care Category, so we have been working really hard to catch up. Yes, we network quite a bit.

Mr. EVANS. Mary-Ellen, I understand CQI is not currently used throughout the Stratton Medical Center. What are the current plans for using it throughout the medical center?

Ms. PICHE. Well, it is, in fact, implemented throughout our medical centers, at the medical-center-wide level and the functional level. In fiscal year 1995 we are attempting to implement at the individual level, getting into personal quality and customer service standards and precisely what we can do as individuals to promote and be a part of CQI.

Mr. EVANS. Regarding the Fisher Foundation, is this the same foundation that has provided these kinds of houses for military hospitals in the past?

Ms. PICHE. That is right.

Mr. EVANS. How was it that your facility became the first VA to have one, and what did the VA have to do? Did VA have to donate the ground, the real estate itself? Can you educate us please.

Ms. PICHE. Yes, we became the first VA to receive a donation through the efforts of that psychiatric nurse I had talked about. She saw that the Fisher Foundation was providing these kinds of comfort homes to armed services installations and thought that perhaps they would be interested in the VA, so she pursued that, and we had to provide the site, the land for it, hookups, plumbing, those kinds of things, and they provided the house.

Mr. EVANS. Well, we hope this will be something that other VA facilities will try to pursue.

Ms. PICHE. And I believe they are, because we have had a number of contacts, and others are pursuing donations.

Mr. EVANS. And the Fisher Foundation is interested?

Ms. PICHE. That is right.

Mr. EVANS. Again we thank all of you very much. Minority counsel doesn't have any questions for this panel. Thank you very much for your innovation and for your caring for the veterans of our country. We appreciate it very much.

The subcommittee thanks each of those who have testified. As today's testimony has shown, every day VA employees are striving to improve services to veterans, sometimes with little public recognition and even less fanfare. VA employees are making better services to veterans a daily reality, and this is very good news for the quality of VA health care.

Ideas and innovations which have been discussed today can be easily exported from one medical center to another. This subcommittee calls on the VA and its top officials to improve and expand networking and information sharing within the VA, develop and support ways and means for local innovations and initiatives

to become widely known and put to good use throughout the entire VA system.

It has been said that every problem presents an opportunity. Witnesses who have testified today recognized those opportunities, and they have responded by improving services to our veterans.

Provide VA employees the opportunity to be innovative and take initiative. Make effective networking a reality so that service improving innovations become widely known and widely used throughout the VA. If this is done, millions of veterans can be better served by the VA. Sometimes at little or no added cost, VA can be the most outstanding service organization in our Federal Government. This subcommittee calls on the VA to make better networking and information sharing a top priority. In the coming weeks we ask them to report to us on their plans to improve networking and information sharing throughout the VA so that veterans everywhere will benefit.

Again, we want to thank every witness who testified. With this we will conclude the hearing.

[Whereupon, at 10:30 a.m., the subcommittee was adjourned.]

APPENDIX

OPENING STATEMENT
REP. TERRY EVERETT

HOUSE COMMITTEE ON VETERANS AFFAIRS
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

AUGUST 3, 1994

Thank you, Chairman Evans, and the Ranking Member Mr. Ridge, for your leadership in holding this hearing highlighting the advancements that have been made in the VA's delivery of services to veterans. From the use of interdisciplinary strategies in the delivery of medical care to providing meaningful job-training opportunities, it is good to hear about these programs and the VA innovators that have helped to make them possible. I was also pleased to learn about the variety of volunteer-based programs that VA health facilities are implementing to help meet the needs of our veterans In view of the current budgetary environment, such initiatives are helping VA facilities meet the important tasks of providing care in a more timely and patient-friendly manner

Thank you again, Mr Chairman, and Mr. Ridge, the Ranking Member, for your leadership on this issue. I also want to thank our witnesses for being here today and for your hard work and innovation on behalf of our veterans. We look forward to your testimony.

Subcommittee on Oversight and Investigations
Improving VA Services to Veterans
Cong. Luis V. Gutierrez
August 3, 1994

Mr. Chairman I would like to commend you for holding this hearing today and welcome all of our witnesses. We receive the opportunity to hear about the positive initiatives that are taking place in the Department of Veterans Affairs far too seldom. Our witnesses today exemplify the initiative and creative problem-solving it takes to make our VA Medical Centers the best they can be.

I applaud our witnesses here today, Mr. Chairman. Each one of them has stepped up to the plate and taken the initiative, more often than not under difficult and confining circumstances.

In going out of their way to create better and more effective services for veterans they have succeeded in accomplishing three very important goals. Number one; they have created a more nurturing, trusting environment between the patient and medical staff. Number two; they have addressed patients special needs creatively and effectively. Number three; they have accomplished these goals within strict cost guidelines, often relying on donations and volunteers.

What strikes me most about the programs these witnesses are involved with is the common sense used to implement them. That is not to say these innovations were not difficult or ambitious to undertake, they were.

But I think sometimes in our desire to use the latest technology or the most up to date, textbook management skills, we overlook the most obvious remedies -- remedies full of common sense.

The witnesses and VA Medical Centers made optimum use of the resources available to them. They streamlined patient-doctor visits, reduced use of expensive medical equipment, used patient representatives to prevent problems from becoming unmanageable and recruited volunteers and donations to establish innovative programs for disabled veterans.

In particular Mr. Chairman, I would like to note the establishment of the Women's Health Care Center at the VA Medical Center in Salem Virginia. The urgent need for women's health clinics cannot be ignored. Women veteran's should not have to endure lesser care simply because of their gender. I commend the Salem facility for ensuring that women veterans receive the comprehensive care they deserve.

Once again, I wholeheartedly applaud you and the work you have a done to make the VA Medical Centers better places for our veterans who, after all, deserve no less than the best care possible. Thank you for testifying today. I look forward to hearing more about your programs.

STATEMENT BEFORE THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

ON

"IMPROVING SERVICE TO VETERANS: INITIATIVES AND INNOVATIONS IN THE DEPARTMENT OF VETERANS AFFAIRS"

BY

THE HONORABLE HERSHEL W. GOBER
DEPUTY SECRETARY OF VETERANS AFFAIRS

AUGUST 3, 1994

***

Mr. Chairman, good morning. I would like to thank you for this opportunity to appear before the Subcommittee to talk about one of my favorite topics -- the members of our VA family, our VA employees.

In my time at VA, I have attended many meetings and hearings dealing with a multitude of issues -- health care reform, Persian Gulf veterans, Agent Orange, homelessness, claims backlogs, radiation exposure and testing, and so on. Everyday we expand our discussions and planning on ways to deal with all of the various challenges that confront us. Depending on the problem, more funding and resources might be called for, or physical plants and new equipment, or application of the latest technology.

But in every instance, at least part of the solution invariably comes down to the same common denominator -- our employees. When I'm on the road addressing various groups around the country, I like to tell them that VA is a success story -- and it is, in spite of what they may have heard in the media -- and that the reason is our secret weapon, our people. It's easy to see why.

When a veteran walks into a VA facility, or picks up the phone and dials our number, he or she is more than likely pretty anxious about the prospect of dealing with one of the largest bureaucracies in the history

of civilization. But to that individual, the VA quickly becomes the first person to greet them in the building, or the voice on the other end of the phone.

Mr. Chairman, I can tell you without reservation that we have some of the finest people in the entire federal establishment working at VA, and even in times of tight budgets and resource reductions, it is those unique people who maintain VA services at the highest level, and who "care for him who shall have borne the battle."

We make it absolutely clear -- our employees are VA's greatest asset, and we have some of the very best in America. With them, we know we will achieve our objectives in serving America's veterans -- putting veterans first.

That is why we are "tapping into" this resource, to get their ideas and apply them to our work processes to improve care, service, and benefits delivery. They provide us with a priceless synergism that comes only as the result of combining their experience, talent and dedication to the proposition of caring for those who have served our nation.

Mr. Chairman, you are about to hear from some of our VA employees who will tell you about some of the innovations they came up with to help improve service and benefits delivery. As you and the other members of the Subcommittee listen to their stories, I would ask that you keep in mind that they are only a tiny sample of the multitudes working for us who have gone out of their way to improve the service that they provide to veterans. They do it not for personal gain, or to make their jobs easier, but simply because they <u>care</u>. I believe that all of us need to show them how much we appreciate what they have done, and ensure them that VA will remain a place where caring people <u>can</u> make a difference in the lives of people who deserve the best that their country can offer.

Mr. Chairman, I thank you for this opportunity to salute our VA employees before the Subcommittee this morning.

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Testimony of

Robert R. Rhyne, D.D.S.
Medical Center Director
Veterans Affairs Medical Center
Grand Junction, Colorado

before the

U.S. House of Representatives
Sub-Committee on Veterans Affairs Oversight and Investigations

August 3, 1994
Washington, D.C.

The Grand Junction VA Medical Center is a 90-bed General Medicine, Surgery and Psychiatry, Level III facility serving western Colorado, eastern Utah, northwestern New Mexico, and southwestern Wyoming. The patient care issues we deal with are much the same as those found in the rest of the VA system, including acute and chronic heart and lung disease, substance abuse, cancer, and AIDS. The metropolitan area of Grand Junction, Colorado, (population 100,000) sits in a valley on the Western Slope of the Rocky Mountains, midway between Salt Lake City and Denver, each about 250 miles away. The Grand Junction VA Medical Center is the second largest hospital in that 500-mile span. As an unaffiliated GM&S facility, and because of our remote location, we provide acute comprehensive care in all disciplines except neurosurgery, invasive cardiology, and open-heart surgery. While the transfer of an acutely ill patient from New York City to Washington D.C. (roughly 240 miles) is rarely accomplished or considered, our professional staff is faced with decisions concerning remote distance transfers every day. Because our catchment area encompasses such a large and diverse geographic area, we are treating patients with higher levels of complexity locally. Only by recruiting an extremely competent and dedicated staff have we been able to make the successful transition to primary care.

In 1987, the patient care medical services within Grand Junction VAMC were organized into two separate entities--ambulatory medicine and inpatient medicine. Prior to 1987, we operated with the general medicine clinic and the general medicine overbook clinic. These clinics functioned five days a week, with an overcrowded waiting room and a general dissatisfaction with the service by patients and health care providers alike. Patients were treated again and again with overwhelming and unnecessary volumes of charts.

Laboratory tests and radiological examinations were ordered during one patient visit, and then the patient was scheduled for a second general medicine clinic appointment with a different provider who asked the same questions and ordered some of the same tests. This cycle was often repeated several times. The unsatisfactory situation was further worsened by an ever increasing workload. The internists worked longer than normal hours, the nurses and MAS clerks found little satisfaction in their jobs, and more importantly, the veterans did not receive the compassionate and continuing care they deserve. The Medical Center personnel clearly had no choice except to find a betier way to deliver care. As a result, a group of physicians, nurses, and Medical Administration Service personnel developed a rather novel operating plan--at least by VA standards at that time. The planning was intensive, and in July 1988, the Primary Care Model was introduced to Grand Junction patients.

Every eligible veteran with a pending general medicine clinic appointment was immediately given an appointment with a newly formed treatment team consisting of a nurse, a physician, and a MAS clerk. Overnight, the patients in our system had a personal physician who would treat him or her in the Outpatient Clinic, admit and care for them as an inpatient in the hospital, and when needed, monitor them through the harrowing experience of the Intensive Care Unit. With time, our patients realized there was always someone within their personal treatment team they could call to discuss a problem or to make an appointment. Each medical clerk and registered nurse was responsible for the practice of two physicians. (In the past year, we have also added a social worker to each primary care team to care for their non-medical needs). The clerks and nurses worked daily with the physicians, thus getting to know their styles of practice, and more importantly, getting to know them as co-workers and colleagues. In turn, the physicians finally had well trained, knowledgeable team members who wanted to make their work easier instead of increasing their frustration. The team concept changed everything for the better.

There are numerous, measurable benefits to our program:

1) Walk in patients, who historically fill the waiting rooms of most VA outpatient clinics, are easily accommodated by our Primary Care Model. Since our patients have an identified team to call, there is no need for them to just walk in, and our "walk in visits" have declined from 42% of all visits to less than 11%.

2) A wider range of health care services have been provided to the ever increasing female veteran population. We are now delivering comprehensive health care to better than 90% of our female patients and were doing so long before it was identified as a high priority of the Veterans Health Administration.

3) Laboratory tests have decreased by 6% and outpatient radiology exams have declined by 12%; the physicians have learned that as they come to know their patients better, they do not order as many unnecessary and duplicative tests.

4) Patient satisfaction at Grand Junction VA Medical Center is high. In a recent survey, we asked patients general questions such as "Do you feel your health care team cares about you," and "Do you have confidence in your health care team?" On a scale of 1-5 with "5" being the highest rating, our score in this area was 4.64.

5) Since the inception of the Ambulatory Care Model, nursing turnover has been nil.

6) When all is said and done, the real success of our Primary Care Model is demonstrated in decreased hospital admissions. While we have experienced a 38% increase in the number of patients treated, our medical admissions to the hospital have declined by 11%. We are convinced this is a direct result of doing a better job in ambulatory care--perhaps scheduling a patient an extra time or two on an outpatient basis to avoid a costly hospital admission. We also conjecture that the emphasis we have placed on our patient education program is reaping better health for our veterans.

In conclusion, the transition to primary care has been an interesting journey with many "detours" along the way. It may sound easy as presented in this short testimony, but there have been some difficult times. It is totally impossible to outline all the nuances of our Primary Care Model or to describe how it evolved. To clearly understand how it works, on must witness the model in action. We invite any and all to call or visit.

During the last 24 months, we have had site visits by professional and administrative staff from many other VA Medical Centers to see operations first hand. We believe our sample model is the most effective and efficient way to deliver comprehensive and continuing medical care to one of the most deserving segments of our population.

In the latest Joint Commission on Accreditation of Healthcare Organizations survey, the Grand Junction VAMC received Full Accreditation with Commendation in both hospital and long-term care programs. This is the highest award given by the Organization--commendation is granted to only the top 2-5% of all healthcare facilities in the United States. We are convinced our Ambulatory Care Program played a significant role in our receiving this award.

Exhibit A

ABSTRACT

The Grand Junction VA Medical Center has established a collaborative practice through the implementation of a Primary Health Care Model. Using the team concept of a professional nurse, physician, and medical clerk, the model offers patients continuity, timeliness, and participation in their health care. Nursing and Medical Administration Services have been involved from the outset in all aspects of the initiation of the program. With the advent of primary care there also has been a management transition to a modified matrix design.

INTRODUCTION

The Grand Junction VA Medical Center is a 90-bed, acute care facility serving western Colorado, eastern Utah, northwestern New Mexico, and southwestern Wyoming. The problems we deal with are much the same as those found in the rest of the VA system, including acute and chronic heart and lung disease, substance abuse, cancer, and AIDS. The metropolitan area of Grand Junction, Colorado (population 100,000) sits in a valley on the Western Slope of the Rocky Mountains, midway between Salt Lake City and Denver, each about 250 miles away. The Grand Junction VA Medical Center is the second largest hospital in that 500-mile span. As an unaffiliated general medical, surgical, and psychiatric facility, and because of our remote location, we provide acute comprehensive care in all disciplines except neurosurgery, invasive cardiology, and open-heart surgery. While the transfer of an acutely ill patient from New York City to Washington D.C. (roughly 240 miles) is rarely considered, our professional staff is faced with decisions concerning remote distance transfers every day. Because our catchment area encompasses such a large and diverse geographic area, we are treating patients with higher levels of complexity locally. Only by recruiting an extremely competent and dedicated staff have we been able to make the successful transition to primary care. In 1987, the patient care medical services within Grand Junction VAMC were organized into two separate entities--ambulatory medicine and inpatient medicine. The Ambulatory Care Department consisted of two rotating internists, two physician's assistants (PA's), two nurses, and four clerks from Medical Administration Service (MAS). The inpatient service consisted of five internists and an inordinate number of ancillary staff. The entities operated, for the most part, independently of one another creating a lack of cohesive effort and understanding.

Prior to 1987, we operated with the general medicine clinic and the general medicine overbook clinic. These clinics functioned five days a week, with an overcrowded waiting room and a general dissatisfaction with the service by patients and health care providers alike. Patients were treated again and again with overwhelming and unnecessary volumes of charts. Laboratory tests and radiological examinations were ordered during one patient visit, and then the patient was scheduled for a second general medicine clinic appointment with a different provider who asked the same questions and ordered some of the same tests. This cycle was often repeated several times. The unsatisfactory situation was further worsened by an ever-increasing workload. The internists worked longer than normal hours, the nurses and MAS clerks found little satisfaction in their jobs, and more importantly, the veterans did not receive the compassionate and continuing care they deserve. The Medical Center personnel clearly had no choice except to find a better way to deliver care. As a result, a group of physicians, nurses, and Medical Administration Service personnel developed a rather novel operating plan--at least by VA standards at that time. The planning was intensive, and in July 1988, the Primary Care Model was introduced to Grand Junction patients. Every eligible veteran with a pending general medicine clinic appointment was immediately given an appointment with a newly formed treatment team consisting of a nurse, a physician, and a MAS clerk. Overnight, the patients in our system had a personal physician who would treat him or her in the Outpatient Clinic, admit and care for them as an inpatient in the hospital, and when needed, monitor them through the harrowing experience of the Intensive Care Unit. With time, our patients realized there was always someone within their personal treatment team they could call to discuss a problem or to make an appointment. Each medical clerk and registered nurse was responsible for the practice of two physicians. (In the past year, we have also added a social worker to each primary care team to care for their non-medical needs). The clerks and nurses worked daily with the physicians, thus getting to know their styles of practice, and more importantly, getting to know

them as co-workers and colleagues. In turn, the physicians finally had well-trained, knowledgeable team members who wanted to make their work easier instead of increasing their frustration. The team concept changed everything for the better.

HOW OUR SYSTEM WORKS

New Patients

New patients are evaluated initially by the triage nurse, one of the team nurses whose physicians do not have a clinic on that particular day. The nurse makes the decision, in concert with the patient, as to the urgency of the visit. A great many of these patients do not need to see a provider that day and are given an appointment in what we call the 10-10 clinic (named after VA Form 10-10m). This clinic is managed by our two Physician's Assistants. Patients are instructed to bring old records and all their medications to that clinic. The PA evaluates the patient, takes care of any immediate needs, requests additional records, and begins the diagnostic work-up. If the problem is straightforward, the PA may elect to keep that patient in their clinic but has the option of scheduling the patient into the next scheduled clinic for a new patient. If the triage nurse determines that patient cannot wait for a 10-10 appointment or if the patient refuses to wait, the PA or the "physician of the week" will see the patient. The "physician of the week" is a valuable individual. The seven internists rotate this assignment which includes seeing the type of patient just presented as well as handling employee health, incoming transfers, and walk-in patients whose primary physician is on leave.

Telephone Triage

If an established patient calls with a concern, the call is routed to the team nurse, who makes several judgments based upon knowledge of the patient and the patient's complaints. Patients experiencing chest pain or other emergencies are directed to call 911. If the concern is minor, advice is given over the phone and the patient is scheduled for an appointment. If the nurse has any questions or concerns, the team physician is consulted immediately. The teams usually meet toward the end of the day to informally discuss the patients who have called in. If, on the other hand, the patient needs to be seen immediately, the case is discussed with the team physician. Most physicians can find a 15-to-20 minute time slot during a busy day to see a patient they already know. In our system, the clerk obtains the chart, the nurse prepares the patient, and a patient visit is accomplished smoothly to the satisfaction of all.

Walk-in Patients

Management of walk-in patients have the potential to upset any system. Since they are already established in the system, they just walk into the clinic expecting to be seen instead of calling ahead for an appointment. In our system, the key question is whether or not their physician is on duty that particular day. If the patient's physician is there, the patient will be seen at the physician's convenience--not the patient's convenience. If the patient's physician is not there, the "physician of the week" will see the patient--once again, at the physician's convenience. Our teams have received unconditional support from Top Management when walk-in patients complain about long waits. Our philosophy is that scheduled patients are our first priority after emergencies; walk-in patients have to wait (sometimes all day).

It did not take long for our patients to know that a phone call is well worth the effort. Our unscheduled visits have declined from 42% of all visits in 1987 to 11% in 1992. (The number is actually lower because the computer will not accept a patient seen outside normal clinic hours as anything but a walk-in). Clearly, our walk in patients are no longer a problem.

Management Concept

The original management model was the traditional hierarchy. Each discipline dealt unilaterally with issues and little interaction between services. Problem-solving through a designated chain of command often had deleterious effects. For example, decisions were delegated to the staff from management with little or no communication regarding how to best resolve problems; this led to

dissatisfaction and a high turn-over rate among the ambulatory care staff. Ultimately, the lack of creativity in resolving patient care issues, plus the low morale of the staff, caused patients to feel their health care was of little concern to the caregivers.

With the inception of the managed care format, a modified matrix design has evolved which has been mutually agreed upon by the clinical and administrative staff. Teams collaborate to solve problems related to patient care and intra-team relationships. The team members have recently been incorporated into the hiring and proficiency evaluation processes. This not only empowers members but also enables them to provide insightful observations that contribute to sound decision-making. Throughout the ambulatory care setting, those who have management responsibilities also practice clinically. This includes people who traditionally assumed only a management role, such as the Ambulatory Care Coordinator, Chief of Medicine, and Chief of Staff; all now also assume a patient-care load in addition to their administrative duties. This philosophy had a positive impact on Ambulatory Care, and in the staff's working knowledge about how the area functions as well as their increased awareness of problems related to patient care.

Benefits of the System

There are numerous, measurable benefits to our program. A wider range of health care services have been provided to the ever increasing female veteran population. We are now delivering comprehensive health care to better than 90% of our female patients (including Pap smears, pelvic and breast examinations)--an increase of 153% in two years. Laboratory tests have decreased by 6%, and radiological examinations are down 5% (both calculated per patient with inpatient and outpatient combined). For ambulatory care only, radiological examinations have declined by 12%. This is in the face of adding an in-house CT scanner and hiring a full-time radiologist. These tests are expensive, and as we have come to know our outpatients better, we have discovered we can often avoid ordering yet another chest x-ray film or CBC. After four years, our no-show rate is low--6% compared to our peer group rate of 10%-11%. Patient satisfaction at the Grand Junction VA Medical Center is high. In a recent survey, we asked patients general questions such as "Do you feel your health care team cares about you," and "Do you have confidence in your health care team?" On a scale of 1-5 with "5" being the highest rating, our score in this area was 4.64.

This system also has accommodated an ever-increasing workload. Our total patient volume is up 38%. Our actual outpatient visits are up 62% due in part to many visits with nurses who have become expert in patient education and have established their own clinics for diabetes, anticoagulation, hypertension, cardiac rehabilitation, smoking cessation, and other problems. We have even launched into the complex worlds of outpatient chemotherapy and comprehensive AIDS care.

When all is said and done, the real success of our system is demonstrated in the decrease of our hospital admissions. Despite the 38% increase in patient volume, our medical admissions to the hospital have declined by 11%. We believe this is because we are doing a better job in ambulatory care (perhaps seeing patients an extra time or two) to save an admission. We also think that some of the time our nurses spend in patient education is paying off.

Our system, however, is fragile. The Number 1 problem is retaining medical clerks. These employees are intelligent, outgoing, able to keep calm in a sometimes harried environment, and they are essential members of our treatment teams. Unfortunately, their present salary structure is not enough to retain them in their job.

Likewise, our nurses are multi-talented, and we cannot afford to lose them. Finding and keeping someone who can staff the Emergency Room, administer chemotherapy, teach a patient how to give insulin, and counsel a veteran whose spouse has just passed away is most challenging. In our view, the way to retain competent nurses is to empower them to use their increasingly sophisticated education. We have taken full advantage of this in our model.

Finally, our system is built around the general internist. The literature is replete with discussions of this dying specialty. A model such as ours cannot function without the expertise of these physicians in both inpatient and outpatient medicine.

THE NURSING PERSPECTIVE

In years past, ambulatory care in Grand Junction VA Medical Center wrestled with difficulties inherent in a general medicine clinic: lack of continuity of care, lack of efficiency and timeliness, and lack of job satisfaction. Also, the veterans expressed dissatisfaction with the general medicine clinic. The health care providers believed that optimal patient care would best be achieved through an established patient/nurse/physician relationship. Consequently, the primary care concept of a team, consisting of a nurse, physician, and medical clerk was developed and implemented in July 1988. Each patient is assigned a primary physician who delivers care on both an inpatient and outpatient basis.

Walk-in Patients/Telephone Triage

Prior to establishing the primary care model, walk-ins had no effective mechanism for communicating their health care concerns. The only choice available was to appear as a walk-in patient to be evaluated. The walk-in traffic grew to unmanageable numbers of high-risk patients receiving inefficient care and who could become extremely frustrated with the excruciatingly slow process.

At this time, the nursing staff was expanded from 2.0 to 3.5 FTEE (1 LPN and 2.5 RN's), and telephone triage was assumed by the RN's. With this development, nurses were incorporated into the primary care teams.

Managing all medical incoming phone calls for the team physician has become an important responsibility of the team nurse. Patients are instructed to call their team nurse between scheduled visits if they feel ill or have questions about the treatment plan. The nurse evaluates the information offered by patients or family members and formulates the best plan of care. This may entail arranging appointments, advising patients, or directing them to the nearest facility for emergent care. Instead of walk-in patients being treated solely by physicians who do not know them, the patients interact with the assigned physician through the team nurse, which assures continuity of care through chronic and episodic illness.

Coordinator of Ambulatory Care/Emergency Room

From the onset of the primary care concept, the leadership for Ambulatory Care was under the supervision of a Medical Director. Upon his retirement in 1992, the Chief of Staff, with the concurrence of the Chief, Nursing Service, developed the idea of the nursing unit manager as Coordinator of Ambulatory Care thus changing the Medical Director's role to that of a consultant. The Coordinator position supervises the Emergency Room, Ambulatory Surgery, and the Mental Hygiene Clinic and is responsible for ensuring collaboration between all clinical and ancillary services, chairing the Ambulatory Care/ER Committee, planning for future needs and goals, managing supplies and equipment, acting as liaison with community health care facilities, solving daily operational problems, and resolving conflicts. If an issue remains unresolved, the Medical Director (defined as the Chief of the Service affected e.g., the Chief of Surgery for surgical problems) is included in the decision-making process.

Nurses' Roles and Responsibilities

Historically, nursing support of Ambulatory Care consisted of one LPN, and the majority of the services available to the patient were delivered through the inpatient mode. The outpatient section was used primarily for evaluating patients for potential admissions and for limited post-discharge appointments. The LPN assisted in all medical, walk-in, orthopedic, and otolaryngology clinics. From 1986 to 1987, the staff was moderately expanded to include three Physician Assistants (PA's) and an RN to meet the increasing needs of a larger patient population and to assist with the expanding functions of ambulatory care. The nurse's role during this phase remained unchanged due to the sheer volume of patients and the extremely limited space. Triage of walk-in patients became the consuming focus for the RN. Providing care in a timely fashion was not possible because of uncontrolled overbooking and numerous walk-ins. This approach to health care certainly was not satisfactory for the provider or the patient. Thus the concept of primary health care was brainstormed as an answer to our problem.

Nursing has been thoroughly involved in the implementation of the program and in the ongoing evaluation process. To accommodate the increase in the patient population and the care needs without additional physician support, two RN's were added. The nursing staff schedules individualized nurse-run clinics and provides care to patients who, in the past, would have been followed up by physicians in their clinics or admitted to the hospital (for example, heart failure patients who need close monitoring; patients changing to insulin, necessitating multiple education sessions; and patients requiring chemotherapy). Using nursing skills to improve care has been a cost-effective measure in comparison to the expense of obtaining additional physician staff. The nursing staff's ability to function autonomously yet practice collaboratively within the team has generated immense job satisfaction, and the turnover of nursing staff since 1988 has been zero.

THE MEDICAL ADMINISTRATIVE PERSPECTIVE

The basic problems prior to the introduction of the primary care model were that all ambulatory care personnel worked in a confined area, and computers were not available, necessitating processing by hand. Often administrative tasks could not be completed quickly enough, and staff from Nursing Service was taken away from patient care to assist MAS. The turnover rate in MAS was 30% in FY 1987--mainly among medical clerks; the primary reasons were the high volume of patients, the stress of the job, inadequate compensation, and the lack of opportunity for promotion. With no team concept and no clear assignment of responsibilities, the medical clerks functioned on a day-to-day basis without a well-defined, primary objective.

From the outset, the medical clerks were a critical component in the implementation of the Primary Care Program. Their ingenuity, motivation, and determination helped us all through those difficult first six months. Starting the primary care clinics and assigning to teams patients who had never experienced any continuity of care was an exercise in mental fortitude. The medical clerks now organize the clinics according to the primary care model. This includes having charts available and complete with appropriate laboratory and radiology results, scheduling follow-up clinic appointments in specialty clinics, and ordering appropriate laboratory and radiology studies. Currently, four medical clerks operate 141 clinics. All our medical clerks exhibit a "take charge" attitude when team members are running behind schedule by directing patients to examination rooms, rescheduling if possible, and explaining in a tactful manner that the physician will be late due to an emergency. These responsibilities are accomplished in addition to new MAS job requirements (training, coding of ambulatory care procedures, Total Quality Improvement and assisting with the Medical Care Cost Recovery Program). These additional demands affect the clerks' ability to devote the necessary time to their original primary care team assignment. Naturally, the clerks perform more competently when staffing is sufficient. It is imperative to the success of the primary care model to keep abreast of its growth and staffing needs. The MAS function is a vital ingredient of the primary care model, and without the work ethic, desire, and team approach of the medical clerks, the program would not be conducted as efficiently and effectively. Staff functions include skills in public relations, knowledge of all clinic schedules, the providers' administrative duties, efficient preparation of the medical records prior to clinics, and the handling of phone calls from team patients with scheduling concerns. Their job also encompasses eligibility issues, knowledge of medical terminology and pertinent VA policies. Their organizational skills provide consistency for the other team members. The support and continuity they provide between the medical care team and the veteran is invaluable. Currently, the turnover rate for MAS clerks has dropped to 9%.

Admissions

Until the last two years, the admission process was characterized by serious problems: (1) lengthy waiting times for patients, (2) patients arriving on a unit with no designated staff member to assist them, (3) no facilitation of patients through the admission process, and (4) less than optimal communication or liaison between ambulatory care and the receiving units. We are actively addressing these long-standing concerns by assigning a nurse to assist patients through this process. Initially, a troubleshooting effort by a nurse in the admission process was implemented so successfully that other services asked to be included. Now, Surgery, Psychiatry, and the Substance Abuse Treatment Programs are using the nurse's services. The admission procedure is constantly evaluated for components

which disrupt patient flow and patient care and reviewed for possible solutions from an interdisciplinary standpoint.

Ambulatory Surgery

The Ambulatory Surgery Unit, which includes sub-specialty clinics, was started in September 1989 and staffed by one RN. Our consultant staff for the sub-specialty clinics was frustrated by the number of patients in each clinic and the time required to gather data and get through the bureaucratic maze. During this period, there was a cystoscopy room and a minor surgery room, both completed 40-48 procedures each month.

As of March 1993, the Ambulatory Surgery Unit has an endoscopy laboratory, with cystoscopy and minor surgery available five days a week, increasing the number of procedures to approximately 150 each month. The Ambulatory Surgery Unit and the Operating Room were combined into one unit, and staff cross-trained for both areas, thus giving a greater flexibility in scheduling. Sub-specialty consultants actually state they now enjoy their VA clinic. When they see their patients, all laboratory and x-ray results are ready for their review when they walk into the examination room. This allows more patients to be seen and fewer visits are required.

THE MEDICAL SERVICE PERSPECTIVE

The Medical Service is staffed with seven general internists. All are American university-trained and board-certified. The Chief of the Service is a practicing clinician carrying a 90% patient load. In addition, the Chief of Staff is a practicing internist devoting at least half of his time to direct patient care. There are also two PA's assigned to Medical Service who work only in Ambulatory Care. Our ICU treats the most seriously ill of our veterans, including those with acute myocardial infarctions and thrombolysis, those requiring invasive hemodynamic monitoring, and those with respiratory failure requiring mechanical ventilation. The Director of the Special Care Unit is one of our staff internists.

The responsibilities of the Medical Service physicians include inpatient as well as outpatient duties and consultations to Psychiatry, Substance Abuse Treatment Program and Surgery Services as well as substantial administrative activities such as chairing most of the standing committees of the Medical Center (Infection Control, Pharmacy and Therapeutics, Blood Usage, etc.). Physicians spend 4 1/2 days a week in the Outpatient Clinic caring for the cadre of patients assigned to them. The rest of their time is spent with inpatients, doing procedures including cardiac stress testing, attending committee meetings, and dealing with peer review, quality management and Joint Commission on Accreditation of Healthcare Organizations mandated activities.

The Primary Care Model involves both the inpatient and outpatient arenas. If a patient assigned to any given internist is admitted to the hospital, that internist is responsible for that patient's hospital care. New patients enrolled in the Outpatient Clinic or admitted to the hospital are assigned to each internist in rotation. Likewise, consultation requests are divided equally. An internist functions as one member of a primary care team in the Outpatient Clinic. The nurse, MAS clerk, and physician are responsible for the health care of a group of patients. If a patient needs care, it is expected that his or her doctor will deliver that care even if it is outside regularly scheduled clinic hours. It is at the discretion of the nurse and MAS clerk to find a time when the physician can see the patient.

All internists, including the Service Chief and Chief of Staff, take night and weekend call in rotation. The internist takes call from 4:30 p.m. to 8:00 a.m. in house, Sunday through Thursday (after having worked a full day from 8:00 a.m. until 4:30 p.m). The day following call is taken off, but due to patient needs, that doctor rarely leaves before noon. Friday from 4:30 p.m. until Sunday at 4:30 p.m. is covered by fee-basis physicians with back-up by the physician of the week (described previously), who makes rounds Saturday and Sunday mornings and takes call on Sunday night. Our system has several advantages. First, all our patients are known to us. We do not have to spend hours reviewing volumes of charts to know what is occurring with each patient. This is especially helpful in emergency situations in which knowing the patient well beforehand can save valuable time. Also, clinics run much more smoothly, and more patients can be seen

in any given period of time. Overall outpatient visit numbers have increased significantly because 1) sick patients are seen frequently in clinic by their assigned internist to avoid hospitalization, and 2) we are continually adding new patients. In contrast, our total number of yearly hospital admissions is decreasing.

The personality factor is another advantage. The nurse/MAS clerk/physician team members know each other's strengths and weaknesses, practice patterns, and habits. In fact, the physicians are involved in the initial interviews, evaluations, and recommendations for the hiring of new MAS clerks and nurses. This modified matrix system has worked out very well.

A major drawback of the Model is the unpredictability of any given day. It is burdensome to a physician to have a clinic full of patients waiting to be seen when the ambulance brings in one of the physician's patients having an acute myocardial infarction. Fortunately, our staff is competent and understanding and does not hesitate to pitch in and help in such situations. Despite the hard work and unpredictable happenings, the physicians of Medical Service are committed to this model. The doctor/patient relationship has been re-established at this small VA, and both doctors and patients seem to be very pleased with the results.

CONCLUSION

The transition to primary care has been an interesting journey with many detours along the way. It may sound easy as presented in this paper, but there have been some difficult times. It is totally impossible to outline all the nuances of our Primary Care Model or to describe how it evolved. To clearly understand how it functions, one must witness the model in action. We invite any and all to call or make a site visit. We believe our sample model is the most effective and efficient way to deliver comprehensive and continuing medical care to one of the most deserving segments of our population.

Statement of

THOMAS L. AYRES
MEDICAL CENTER DIRECTOR
VETERANS AFFAIRS MEDICAL CENTER
AUGUSTA, GEORGIA

Before the Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
U.S. House of Representatives

Washington, D.C. - August 3, 1994

The VAMC in Augusta is a two-division, 1033-bed, Complexity Level I medical center. The Downtown Division is a 380-bed acute medical and surgical facility including a 60-bed Spinal Cord Injury Unit. The Uptown Division is a 653-bed psychiatric, intermediate medicine and rehabilitation facility and includes a 60-bed Nursing Home Care Unit. The VAMC in Augusta employs 2,300 staff members with an annual budget of approximately $130 million. I was appointed Director at Augusta in June, 1990. I have always felt that there was a need for a direct channel of communication and mediation between medical center management and individual patients, their families and other consumer groups. Based on this feeling and my previous experience with Patient Representative Programs, I felt very strongly the need to develop and implement a proactive program at Augusta. Having a Patient Representative Program enhances the quality of care provided and increases the medical center's perceived sensitivity to the needs and concerns of veterans and their families by being responsive to inquiries; by incorporating the veteran's viewpoint into the policy making process; by ensuring their awareness of the programs and opportunities available at this medical center; and by evaluating the effectiveness of existing programs to ensure the medical center is meeting the needs of its consumers.

The Patient Representatives Program was initiated in October, 1990. A total of five FTEE were allocated and hired. Due to the fact that our Patient Representatives cross all lines of authority in the medical center, I placed this program organizationally under the Office of the Medical Center Director.

Patient Representatives work a variety of tours of duty, including evenings, weekends and holidays. Patient Representatives rotate on a quarterly basis among the established tours. They are thereby able to stay abreast of issues or concerns throughout the medical center. Our program is proactive in that staff seek out and attempt to identify patient/family concerns and problems in their earliest stages. Patient Representative staff members visit with new admissions to the medical center and maintain a visible presence in our Ambulatory care area (outpatient). Patient Representatives act as a liaison service between the patients and institution as a whole and between the institution and community it

serves. In so doing, Patient Representatives truly mediate for the patient with those in authority.

We believe the major benefits at Augusta are as follows:

- Improvement in the quality of care provided. The Patient Representative Program is able to identify problems/concerns of its consumers and recommend changes in policies and procedures. Through the Patient Representative Tracking Program, complaints are tracked and trended as part of a continuous improvement in health care delivery.

- Cost effectiveness through appropriate utilization of time by staff. Patient Representatives are often able to resolve complaints/concerns at the lowest point in the organization. Medical center staff refer patient concerns/problems which are beyond their scope of duties to the patient representative. Referrals to Patient Representatives are appropriately handled without the referral having to go through several different layers before obtaining resolution.

- Cost savings from potential risk management cases. The Patient Representative Program has demonstrated the ability to identify potential risk management cases or issues. An important element in many malpractice suits is the patient who has experienced a complete lack of identity. People tend to sue people they don't know or who have not taken the time to know them. The Patient Representative plays a critical role in maintaining a line of communication and in developing personal relationships with the patient. By doing this the patient does not feel ignored or alienated.

- Increased satisfaction by patients and staff about the medical center. Patients, families and medical center staff have been very positive and supportive of the Patient Representative Program. Their perception is one of improved services, prompt resolutions to their concerns, and an overall increase in patient satisfaction with the medical center.

- Positive public relations. The Patient Representative is one of the most important staff members in the medical center for influencing public opinion. Patient Representative staff have the opportunity to project a positive image of the medical center through numerous contacts with patients, families and other consumers in the community.

I would be pleased to answer any questions you may have.

STATEMENT OF
BARRY L. BELL, DIRECTOR
PORTLAND VETERANS AFFAIRS MEDICAL CENTER
BEFORE
THE HOUSE VETERANS' AFFAIRS SUBCOMMITTEE
ON OVERSIGHT AND INVESTIGATION
"IMPROVING SERVICES TO VETERANS: INITIATIVES AND INNOVATIONS IN THE DEPARTMENT OF VETERANS AFFAIRS"
AUGUST 3, 1994

Good Morning. It is a pleasure to be here today and to have this opportunity to speak to you about the Portland VA Medical Center's innovative programs that enhance our ability to provide efficient and effective quality care. We have three primary areas that we have focused on to improve care in Portland: 1) Innovations to improve patient access to health care services and the coordination of care, 2) Innovations through new direct patient care programs and 3) Innovations in our administration and planning of health care services.

Innovations to Improve Patient Access to Health Care Services and the Coordination of Care

PVAMC has been a leader in the development of highly coordinated and efficient patient-centered care. From the patient's first contact with the Medical Center through discharge from an inpatient visit, we have implemented innovative programs to ensure continuity of quality care that best meets the patient's needs. A few of the most important programs include:

- Telephone Care Program

Goals: Implementation of the Telephone Care program began March 6, 1989. Telephone Care was the result of a three year project to ensure more efficient use of resources by balancing patient care needs with the appropriate level of care. Until the Telephone Care Program, patients were accessing non-emergent care and many times administrative services by walking into the Emergency Care Unit. Unscheduled workload caused long waiting lines, lost efficiency and jeopardized our ability to provide emergent care to those most in need. The goals of the program included reducing the high number for unnecessary walk-in, non-acute workload to the Emergency Care Unit, the creation of a smooth process for patient access/re-access to the Medical Center, improvement of responsiveness to patient medical questions and concerns, and reduction of overall cost of care by controlling the use of our resources.

Model: Implementation of the Telephone Care Program was preceded by the establishment of the Primary Evaluation Clinic (PEC). This clinic provides scheduled appointments for non-acute patients who require timely evaluation for triage into the clinic system or elective admission without the need for emergency services. The Telephone Care Unit schedules non-urgent appointments within 10 days to prevent patients from becoming discouraged and "walking in" to the Emergency Care Unit.

Patients calling the Portland VA Medical Center are directed to the Telephone Care Program (TCP) which consists of six components (Attachment A):

1. Ambulatory Care Patient Services Assistants (PSAs) screen and refer calls to the appropriate clinical component of the Telephone Care team. PSAs also process patient complaints and answer a variety of non-medical questions about accessing various services and programs.

2. Advice Nurse: Responds to medical concerns and questions from patients who do not have a clinic provider or who call with urgent problems.

(Telephone Care, cont.)

3. Advice Pharmacist: Assists patients with medication refills between visits and answers questions regarding current medications.

4. Eligibility Hotline: Medical Administration employees provide information regarding eligibility and entitlement and streamline the process of access to care by allowing telephone registration and means testing of new patients.

5. Primary Nurse: Ambulatory Care Nursing staff in the hospital based clinics and the satellite clinic are the vital link between the patient and his/her provider.

6. Patient Representative: Provides program oversite for patient complaints and deals with complex problems beyond the ability of the Patient Services Assistants.

In addition to establishing a Primary Evaluation Clinic, the role of the Ambulatory Care nursing staff was enhanced. Each outpatient nursing staff member was assigned a block of clinics and given responsibility to facilitate problem resolution for patients between outpatient visits. The nurse's were given the authority to schedule patients for earlier visits including over-booking to allow an urgent appointment if necessary.

Benefits: Positive outcomes of the Telephone Care Program are improved continuity of care, a case management approach to health care, improved control of workload, improved Patient Satisfaction (90+ percentile by recent survey), better coordination of care between different kinds of providers, early identification and resolution of system problems, improved quality of care, increased opportunities for patient education, and improved access to care. Since the beginning of the Telephone Care Program, Emergency Care Unit visits have dropped over 19% while Telephone Care clinical calls have steadily increased by over 211%. (Attachment B). In 1993 over 53,000 calls were processed by the Telephone Care Program, over 25,000 of which were clinical calls.

Savings: The savings of implementing the Telephone Care Program at the Portland VA Medical Center are directly related to the improved control of workload. The savings created through the dramatic reduction in the demand for non-emergent services in the Emergency Care Unit and through overall improved efficiencies in the clinic has far outweighed the personnel dollars needed to staff the Telephone Care Unit.

- **Short Stay Care Unit**

Goals: The Short Stay Care Unit (SSCU) opened April of 1990 to provide an area for patients who were presently being admitted to the hospital but could receive their care as outpatients. Prior to the opening of the SSCU there was no area for patients to receive outpatient treatments such as blood transfusion, GI procedures, day surgery, IV antiblotics, and several other treatments. SSCU provides an area for many AIDS patients to receive care. The area also provides a place for recovery of patients who receive IV sedation as outpatients.

Model: The eight station unit is available to all medical and surgical services in the Medical Center. The average length of stay for the SSCU patient is 4.5-6.0 hours. All patients receive pre-procedure and post procedure phone calls from the nurses in the unit. Surgery patients are screened as outpatients prior to arrival in SSCU for medical problems that may interfere with their surgery. The SSCU offers the same high-quality care while eliminating the need for a more costly intensive and lengthy hospital stay. Care in the SSCU is individualized to the most effective and appropriate level of care and treatment is performed by consistent care givers. There have been over 10,000 patient visits to the SSCU since it opened.

(Short Stay Care Unit, cont.)

Benefits: The Short Stay Care Unit has significantly contributed to a 22% reduction of inpatient discharges through the shifting of workload to a more appropriate level of care (Attachment C). Continued growth is expected as more conversions from inpatient to outpatient are anticipated. Due to the success in the usage of the SSCU, a second unit of eight stations was opened in July, 1994, thereby doubling the unit.

- **Womens' Multidisciplinary Breast Clinic**

Goals: To establish a medically and economically effective, patient-oriented clinic focused upon breast diseases and conditions of women. The Multidisciplinary Breast Clinic (MBC) was initiated in October 1991, in an effort to create continuity of care with committed specialists in breast disease through an outpatient setting.

Model: The Multidisciplinary Breast Clinic is available by referral from primary care physicians for general complaints. The MBC is administrated by a clinic manager who is singularly responsible for the application of an administrative system servicing the patient and fully supportive of the health care providers. Patients receiving a biopsy receive a same-day consultation with the appropriate specialist. The core group of key participants in the MBC include the RN clinic manager, surgical oncologist, medical oncologist, radiation therapist, mammographer, and cytopathologist. Available to any patient is an anicillary group including a primary care physician (OB/GYN and family practice), plastic surgeon, psychiatrist, and medical social worker. Special focus is placed on same-day test results with maximal utilization of available outpatient diagnostic and therapeutic modalities for each patient.

Benefits: Because of the emphasis on providing patients with test results on the same-day, patients with benign breast conditions can leave the clinic relieved they do not suffer from the malignancy they feared. Patients with malignancy have the opportunity to face their disease with immediate support from a variety of social and breast disease experts. Both types of patients are comforted knowing they are being cared for by a multidisciplinary team of experts. Physician colleagues in other areas are relieved that a mechanism exists whereby their patients with breasts problems may be quickly and effectively evaluated and cared for on a long term basis. The MCB has seen over 3,900 patient visits since it began.

- Difficult, Dangerous and Drug-Seeking Program

Goal: In addition to the bio-technical challenges of modern health care, some patients' behaviors complicate the doctor's goal of helping them remain healthy and minimize the effects of chronic diseases. At PVAMC, our goal is to provide safe and appropriate medical care to every eligible veteran who is willing to work with us to that end. To accomplish this goal, we have establish three inter-linked programs to help us provide care for difficult, dangerous and drug seeking patients.

Model: Although some 3-D patients deliberately create the above mentioned problems, we need to recognize that many are simply frustrated with trying to negotiate a complex and sometimes fragmented system of health care. The PVAMC 3-D Program is a positive, structural approach designed to identify these patients and gain their cooperation in the health care process (Attachment D).

(Difficult, Dangerous and Drug-Seeking, cont.)

When providers in our institution feel that their ability to provide quality care is jeopardized by patient behavior, they can contact the Chief of Staff, describing the problem and their unsuccessful attempts to address it, and request consultation in devising an effective plan which can be consistently implemented throughout the medical center. After multidisciplinary review by the Coordinated Care Review Board, the Behavioral Emergency Committee or the Drug Seeking Behavior Committee, a plan is formulated to offer care to the veteran in a way that assures safety and appropriateness.

The patient care plan is communicated to all staff via the computerized patient record so that our approach is consistent. Whenever the patient comes to the medical center, be it at the emergency room, an outpatient visit or the pharmacy, staff are advised about how to provide a setting which encourages cooperation with care.

Benefits: As a result of these programs we have documented a 90% reduction in violence in our emergency room and other settings, while still providing care to patients with a history of violence or threats of violence. For patients referred to the Coordinated Care Review Board, there has been an 50% reduction in emergency room visits and a 25% reduction in the number of different doctors caring for a patient, while continuing to provide care, in most cases. (Attachment D)

Improved Coordinated Care through ACGME Funds

- **Medical Assistant Program**

Goal: The Medical Assistant Program was developed to provide enhanced administrative and clinical support to busy clinics with residents to improve their efficiency and improve the convenience of services to outpatients.

Model: The Medical Assistant provides a variety of tasks in the clinic that include: exercise treadmill testing, ear wax removal, drawing specialty blood samples, measuring lung functions and conducting electrocardiograms. In addition to these on-site services, the Medical Assistant improves the flow of patients by assisting patients into gowns and with dressing after examinations, locating the necessary documents for the doctor, stocking examination rooms, and entering doctor's orders into the computer.

Benefits: The Medical Assistant Program speeds up the patient's visit to the clinic by coordinating their entire appointment. The program has also reduced the need to send outpatients to other areas of the hospital for services, and has increased the nurse's ability to provide patient education and telephone care for clinic patients.

- **Surgical Team Facilitators**

Goals: The Surgical Team Facilitator program began in September 1991 with Orthopedic and Urology facilitator positions and was expanded in January 1993 to support additional surgical specialties. The goal of the Surgical Team Facilitator role is to free-up Residents' time from administrative paper work, thereby allowing them more time for direct patient care and surgery. Their role is to ensure continuity and efficiency of care for surgical patients throughout their pre-operative outpatient, inpatient, and post-operative outpatient care.

(Surgical Team Facilitators, cont.)

Model: The Surgical Team Facilitator works directly with surgical patients to coordinate/review the administrative aspect of the consult review, clinics, admission, and surgery schedule. Responding to the numerous phone calls received in the house staff offices, the Facilitator can directly answer patients' questions without interrupting the residents. In the case that the caller needs to speak to the physician, the Facilitator understands what information is needed by the resident, i.e.: medical record, health care summary, pharmacy list, and makes the appropriate information available. The Facilitator contacts patients to schedule admissions and new clinic appointments, calls the patient to reschedule when they miss a clinic appointment and coordinates the scheduling of labs, x-rays, and reviewing consults. Surgical Team Facilitators treat the needs and concerns of the veteran as a priority and balance the administrative needs of house staff, resulting in a coordinated effort for patient care through a specific surgical specialty.

Benefits: The Facilitator role has reduced the length of stay for inpatients and reduced the number of outpatient clinic visits for surgical patients. These Facilitators also provide for more effective management of bed control and emergency room issues in the transfer and admission of patients.

Innovations in Patient Care Programs

The Portland VA Medical Center has implemented numerous patient care programs which not only enhance overall health care but which focus on addressing the special needs of our veteran patients. Examples of these innovative programs include the following:

- **Patient Lodging Units**

Goals: Some patients receiving specialty services from the VA had to travel long distances from their homes, in many cases across the United States, and then remain in the Portland area in order to get ongoing treatment. Two lodging areas were installed to allow liver transplant patients and radiation patients and their family members a place to stay while the patient is receiving care and recuperating from treatment. Before the lodging units were available, the only other option was to either place the patient unsupervised in a motel if they were physically able, or in a nursing home. Of those radiation patients placed in a nursing home, 60% did not need the specialized and expensive care found in a nursing home.

Model: Patients who live outside of a 50 mile radius and cannot stay with relatives or friends in the area are evaluated for their need for temporary housing. Liver transplant lodgers may bring a family member while they go through the extensive process of pre-operative testing through post-operative recovery. Radiation therapy lodgers are also allowed to bring a family member on a space available basis. The radiation patient lodging unit offers a total of ten beds for patients and their family members. The liver transplant patient unit has 30 beds with an additional eight beds opening within the next month. Full kitchen facilities are included in both lodging units and meals are available in the canteen as well. Social Work Service coordinates the lodging program from the initial evaluation of the patient through their discharge planning, providing for thoroughly coordinated care throughout the patient's treatment.

(Patient Lodging Units, cont.)

Benefits: The radiation and liver transplant patient lodging program meets a variety of needs for patients faced with a life-changing medical procedure and treatment. Over 105 veteran patients and eight family members have stayed in the radiation lodging unit. Over 170 veteran patients and 170 family members have stayed in the liver transplant lodging unit. Not only does it directly support the patient and enhance their quality of care, the lodging units have also reduced the number of late and missed appointments that were caused by extensive travel time. Allowing a family member to stay with the patient not only enhances the healing environment but also provides needed emotional support for those patients facing a terminal disease.

- **Orthopedic Patient Education Home Video**

Goal: The inception of the Orthopedic teaching video occurred one year ago when orthopedic clinicians identified a need for improved preoperative joint replacement instruction for those patients scheduled for surgery to prepare for the many postoperative domestic changes. Patients needed preparation for this procedure in order to strengthen muscles in the affected leg and to be able to make necessary changes around the home since activity would be limited for up to eight weeks.

Model: A class was initiated for these preoperative Orthopedic patients which included information needed to make a smooth transition from "invalid" to their regular activities. A videotape of the class is sent to patients unable to attend. Patients return the video when admitted for the Total Hip or Knee Replacement.

Benefits: The videotape program meets the needs of patients who live in remote areas and find it difficult to attend preoperative classes. The videotape format is also conducive to patient education. Patients can review the video taped material as often as necessary when it is convenient for them. Plans are underway to produce other videotapes about preoperative instructions.

- **Northwest Indian Veterans Advisory Council**

Goals: The Northwest Indian Veterans Advisory Council was created in 1990 to respond to the special needs of Native Americans through a greater understanding of their culture and history. The Committee serves to create communication channels and partnerships for the under-served population of Native Americans.

Model: Several communication channels have been put in place as a result of the creation of the Advisory Council. Native American Spiritual Healers are working with the Chaplain Service to provide traditional healing services for Native American inpatients. A Patient Assistant to American Indian Veterans is currently being recruited through our partnership with the Indian Health Service and the Northwest Pacific American Indian Health Board to more pro-actively meet the needs of our American Indian veterans. In addition, a Northwest Indian Outreach office has been established at PVAMC and continues to be a center for communication between American Indians and the Medical Center.

Benefits: The Northwest Indian Outreach Office has a client base of over 500 veterans. Our ability to serve American Indian Veterans has been greatly enhanced as communication has increased. For the third year in a row, PVAMC has been invited by the Northwest Indian Veterans Association to attend a four day workshop at Camp Chaparral, located on sacred Yakima Indian ground, to receive cross cultural training on American Indian traditional healing practices.

- **Vets Express**

Goals: Vets Express is a partnership between the VA and local veteran service organizations to improve access to health care for both disabled veterans and those from rural areas. This pilot project directly meets requests by veterans for coordinated, low-cost transportation while utilizing the support of volunteers and close relationships with service organizations.

Model: The Vets Express Transportation Network is coordinated with the Roseburg VAMC, White City Domiciliary, and Eugene Vet Center. The daily round-trip to the Southern Oregon VA facilities is over 355 miles. Specially trained volunteer drivers are scheduled through the DAV's full time Hospital Transportation Coordinator located at PVAMC. Donated vans with wheelchair lifts and two-way radio systems assure a safe trip. Shuttles are scheduled Monday through Friday. Veterans from rural Oregon can easily arrange for transportation to and from their appointment or inpatient stay. Vets Express has added a daily Central Oregon route of over 320 miles round-trip (Attachment E).

Benefits: Vets Express transports an average of 16 patients each day, along with medical records and VA equipment and supplies. After expenses and greatly improved convenience for veterans, $7,500 in beneficiary travel costs are saved each month as a result of this program.

- **The "Class of '45"**

Goal: The "Class of '45" is a VA Outpatient program initiated in 1982 for older male problem drinkers which has since served as a national model. The original program goal was to focus on the issues of the older alcoholic, the double stigma of aging and alcoholism, along with the self blame and shame prominent in older patients. Earlier experiences also showed that older veterans often expressed dissatisfaction when placed in group therapy with younger patients and they tended to drop out of such treatment prematurely.

Model: The "Class of '45" includes a thorough evaluation and management of coexisting medical and psychiatric problems. Group leaders possess backgrounds not only in alcoholism but special training in social and counseling issues among the elderly. A more gentle approach to drinking relapses is used to preclude the veteran's self-blame from causing them to simply drop out of the group. Special logistics such as daytime appointments and an area for informal socializing are addressed to meet the older veterans' needs.

Benefits: The "Class of '45" has been very successful at meeting the specific needs of our older veterans. Approximately 60% of the patients complete the program, about twice the completion rate then when older patients are mixed with younger patients. Over 400 older veterans have entered the program since it began.

Innovations in Patient Care Program Administration

Part of improving our service to veterans has meant looking at the overall picture of providing health care. Our innovations in program administration have freed up resources to start new or expand existing care programs. It also gives more time to clinicians for direct patient contact and fosters a comprehensive, coordinated approach to program oversight. Improving care to veterans means improving not just what services we offer and how we coordinate them but how we manage all our resources throughout the continuum of health care management.

- **Total Supply Support**

Goal: Traditionally, each individual service in a VA Medical Center has maintained their own inventory of medical/surgical supplies by using clinical staff to inventory and prepare requests to replenish these supplies. These same clinical staff have also had to prepare budget requests and maintain the Service's fund control points. The Total Supply Support program was initiated in 1990 to relieve clinical staff of this time-consuming administrative function.

Model: The Total Supply Support program is coordinated by Acquisition & Material Management Service which trains employees in purchasing and inventory management techniques and places them in the clinical service area being served. By utilizing the latest in bar code technology, these employees, referred to as Item Managers, take on the responsibility of inventorying and replenishing the clinical service's supplies as well as preparing annual budgets and maintaining fund control points on a daily basis.

Benefits: There are several key benefits to this program including: 1) the clinician has more time to take care of patients, 2) on-hand inventory levels are significantly reduced while item availability has greatly increased and, 3) improved costing information is instantly available. In a period of just 17 months, our Total Supply Support program has reduced the monthly, on-hand supply of inventory value of our Supply Processing and Decontamination Section from $675,000 to just under $200,000 while still supporting a 95% fill rate.

- **MORE $ (Managing Our Resources Effectively)**

Goal: Implemented in 1989, the More $ program decentralized personnel services dollars and abolished service FTEE requirements. This allowed greater flexibility for services to allocate funds where they are needed most. Service Chiefs learn to manage personnel resources within their assigned budget and to maximize their dollars in all aspects of personnel management.

Model: Unlike under our old FTEE budgeting system where managers did not differentiate the financial impact of a GS-3 versus a GS-11 employee on their personnel budget, the MORE $ program makes managers responsible for matching the most appropriate skill level to the position. Managers are now empowered to effectively manage all aspects of personnel budgeting including oversight of overtime and sick leave through an expanded data base provided to the manager. The More $ program also provides an added incentive for services to manage their resources more efficiently. Services that are able to achieve a savings by the end of the fiscal year receive returned incentive dollars on a nonrecurring basis. These dollars may be used by the service to further specific program goals within VA guidelines.

(MORE $, cont.)

Initial allocations were based on each service's assigned FTEE ceiling and approved grades listed on its organizational chart. Adjustments are made for any changes in programs, or funding levels approved, subsequent to the establishment of the service's initial allocation.Under the MORE $ program, managers become better attuned to the real cost of providing services.

Benefits: PVAMC was the first VA Medical Center to give all Service Chiefs the opportunity to manage their personnel budgets. When the Joint Commission on Accreditation for Healthcare Organizations (JCAHO) recently required in its latest survey standards that all Nursing Services implement a dollar budget system, Portland was used as the model in the Western Region. The MORE $ program has also given Service Chiefs flexibility to make necessary adjustments in anticipation of health care reform.

- **Multidisciplinary Approach to Program Oversight:**
  Ambulatory Care Executive Board (ACEB)
  Inpatient Executive Board (IPEB)
  Extended Care Executive Board (ECEB)

Goals: The purpose of the ACEB, IPEB, and ECEB is to ensure the most effective and efficient means to meet the needs of the patient while matching resources to workload. These multidisciplinary boards were also implemented to provide representation, leadership, accountability and advocacy in a medical system which is traditionally managed by service chiefs based on discipline rather then programs.

Model: The Extended Care Executive Board was formed in 1979 and has the authority and responsibility for management of all Extended Care programs.

The Ambulatory Care Executive Board was established in 1989, providing the direction and goals for the Ambulatory Care Program and acting as an advisory body to the Medical Center's top management.

The IPEB was established in 1993 and addresses issues of planning and management for all inpatient programs.

Benefits: The multidiscplinary approach to managing programs and resources has facilitated planning and resolution of clinical issues and aided in the execution of normally complicated and slow decision-making processes. After studying the development and contributions made by the ECEB, VA Central Office issued a directive in April, 1994, that requires all VA Medical Centers adopt similar planning bodies and practices.

- **Position of Director, Ambulatory Care Programs**

Goal: In 1985, PVAMC opened the doors of its expanded satellite outpatient clinic with a goal of growing from 28,000 visits to 66,000 within five years. The Associate Chief of Staff for Ambulatory Care identified a need for an individual who could address problems which crossed service lines and disciplines in order to keep problems from falling through the cracks. This position needed the authority to cross organizational lines, effect change, coordinate expansion of services, make program decisions and commit space and support staff resources for the purposes of expanding workload.

(Director, Ambulatory Care, cont.)

Model: The Director of Clinic position was created and placed under the supervision of the Medical Center Director. The position was later expanded to Director, Ambulatory Care Programs to include responsibility for the hospital based clinics. The Director of Ambulatory Care Programs ensures the complete coordination of ambulatory care. With the addition of an administrative Director to the management of ambulatory care, there is someone directly responsible for seeing that patients are cared for in the most appropriate setting based on their clinical needs, ensuring providers accept responsibility for their clinic patients at all times, developing processes to facilitate patient/physician communication, providing improved technical and administrative support to clinicians and improving the quality of patient care.

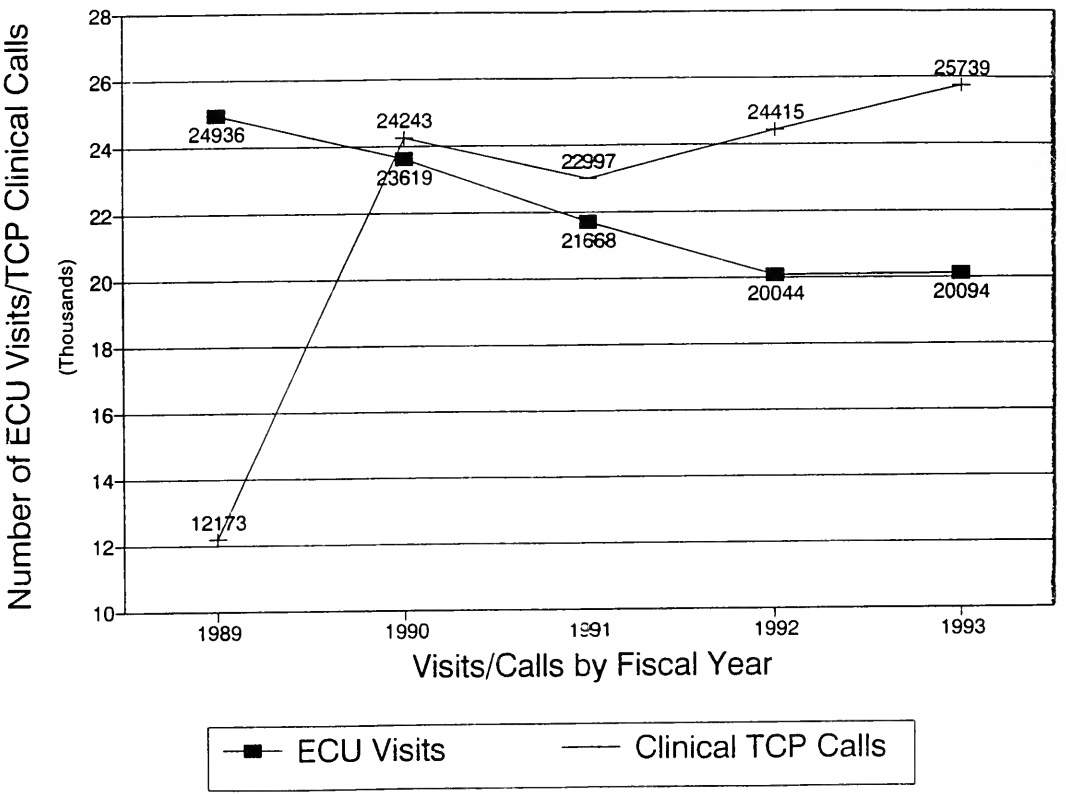
Benefits: In essence, the Director, Ambulatory Care has been the person in charge that could make things happen regardless of the scope of change needed. By providing a position which covers the day-to-day management, there has been much more accountability for all services and programs in ambulatory care. Innovative programmatic oversight and leadership provided by the administrative Director, Ambulatory Care Programs, in concert with the ACOS for Ambulatory Care has positioned PVAMC to be better prepared for National Health Care Reform.

The results of the ambulatory care program under the supervision of an administrative Director have been the development of the Primary Evaluation Clinic to provide access to care for patients with no clinic provider and eliminate unnecessary trips to the Emergency Room, the development of a Telephone Triage system (Telephone Care Program), development of an expanded Nursing role in clinics to enhance the quality of care delivered, reorganization of clinic schedules and patient flow, and improvement in access to care in subspecialty clinics.

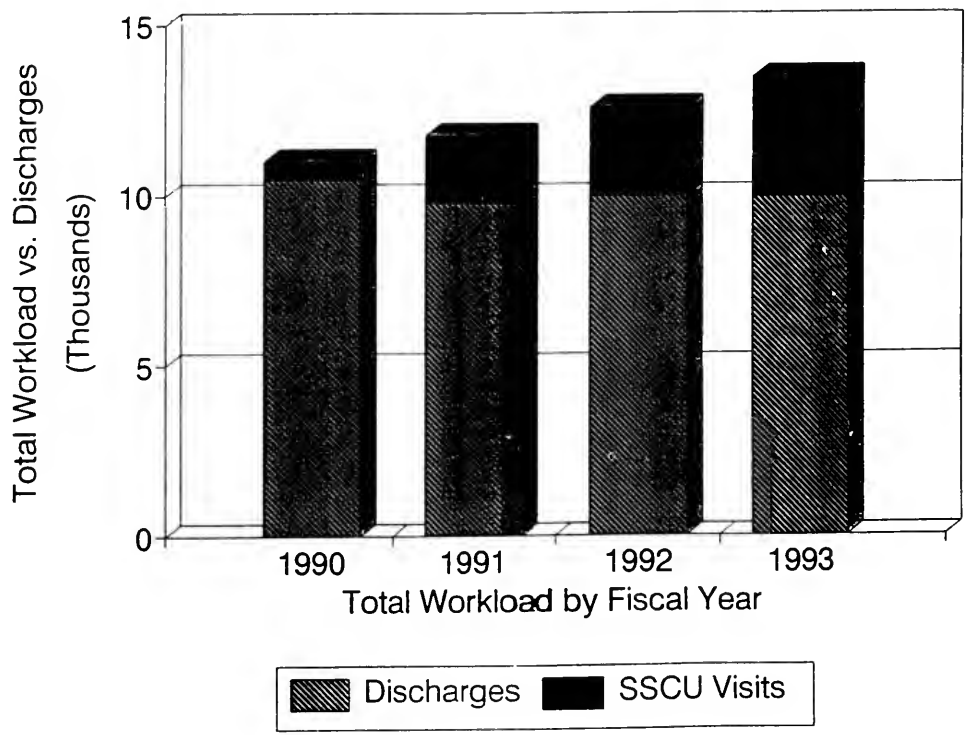
Attachment A

Telephone Care Program (TCP) Model

ECU Visits vs. TCP Clinical Calls by FY



Total Workload vs. Inpatient Discharges



Attachment D

Difficult Dangerous Drug-seeking

A Successful Program to Care for Your 3-D Patients

• Developed by Portland VAMC •

WHO ARE 3-D PATIENTS, AND WHY SHOULD YOU CARE ABOUT THEM?

Difficult, dangerous and drug-seeking patients are a fact of life, especially in VA Medical Centers. They are patients who interfere or refuse to cooperate with treatment for illness and injury. They behave in violent and abusive ways. They seek multiple prescriptions and unnecessary drugs, often for resale on the streets.

3-D patients create headaches for both administrators and staff:

- They threaten the safety of hospital staff and increase stress.
- They overuse Medical Center resources, especially emergency rooms.
- Their lack of cooperation in following treatment leads to more severe illness and higher treatment costs.
- They create public relations problems for the medical center when they complain to legislators.
- They create chronic administrative problems through excessive complaints and paperwork.

Although some 3-D patients deliberately create the above-mentioned problems, we need to recognize that many are simply frustrated beyond all reason with trying to negotiate a complex and fragmented system of health care providers. The Portland VAMC 3-D Program is a positive, structural approach designed to identify these "problem" patients and gain their cooperation in the health care process.

A PROVEN, EFFECTIVE SOLUTION FOR HELPING 3-D PATIENTS

The Portland VAMC 3-D Program is an effective, low-cost approach that can be used in any hospital. The program:

- Is easy to implement.
- Reduces the administrative hassle of dealing with chronic problem patients.
- Provides better, safer patient care.
- Reduces health care overutilization.
- Decreases the risk of patient legal action.
- Improves public relations, especially with legislators.

The program uses three strategies to manage 3-D patients:

- Coordinated Care Review Board
- Drug-seeking Behavior Program
- Behavioral Emergency Committee

The 3-D strategies are supported and coordinated by the offices of the Medical Center Director and Chief of Staff. This top-down support allows the medical center to speak with one voice to 3-D patients and third parties interested in their care.

COORDINATED CARE REVIEW BOARD (CCRB)

The Coordinated Care Review Board helps providers care for patients who are uncooperative or deceptive, misuse VAMC resources, and/or seek multiple providers in ways that disrupt care. The CCRB is chaired by a psychologist and comprised of physicians, psychiatrists, surgeons, nurses, the VA's attorney, a patient representative (advocate), and other administrators.

How It Works

The CCRB sets limits and guides patient behavior in a positive way, specifying the conditions in which the medical center can help and guiding patients towards safe health care.

1. **Multidisciplinary Review:** The Board provides multidisciplinary review of cases referred to the hospital Chief of Staff because of behavioral difficulties that threaten the staff's ability to deliver safe medical care. This review establishes a record of thoughtful consideration of patients' needs.

2. **Training:** The results of these reviews are recommendations for patient care which are implemented throughout the medical center. These may include Board members helping the provider enhance interviewing skills for challenging patient encounters.

3. **Communication:** One of the CCRB's primary tools is the *health care agreement*. The agreement is a written document that clearly states for patients the behavior that is necessary on their part for safe, effective health care. The agreement communicates the medical center's expectations for things that patients need to do, such as keep their appointments and take their medicine, in order for physicians to provide health care. It also notifies the patient that the medical center will not provide care if conditions for safe care are not met.

   The CCRB also facilitates communication between medical center staff by placing a "flag" in the patient's computer file that alerts providers that a special plan is in place for providing care.

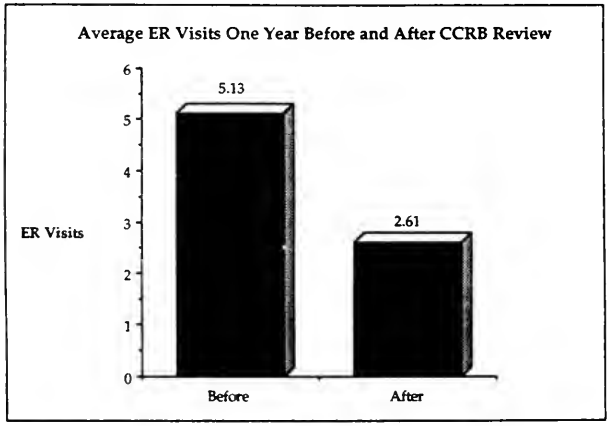
4. **Coordination:** The CCRB approach provides for coordination of all the patient's health care through a single, continuity-of-care provider. The CCRB helps the Chief of Staff's office provide monthly reports to the provider about the patient's use of services, keeping of appointments and Emergency Room visits so the provider can identify when the patient is deviating from the agreement.

   The Board and the Chief of Staff also work with the Medical Center Director to coordinate responses to inquiries from congressional representatives, VA Regional and Central office and other third parties who sometimes become involved regarding individual patients.

CCRB - Portland VAMC Results

The CCRB's positive, structured approach to managing 3-D patients has achieved dramatic results with better care for patients. Patients reviewed by the Board had *50 percent fewer Emergency Room visits* and significantly fewer total VA providers the year after the review.

The strategy has been well received by the local staff of congressmen, congresswomen and senators, who sometimes inquire about the care of their veteran-constituents. It also has been sustained by independent review from the VA's Inspector General.



CASE STUDY — CCRB IN ACTION

A 46-year-old male veteran who was 30 percent service-connected had a history of 23 surgeries and many hospitalizations for recurrent blood clots with pulmonary emboli. He had a long history of noncompliance with outpatient anticoagulation therapy, for which regular monitoring of critical blood factors and subsequent medication adjustments were required. Despite multiple education efforts, the patient continued to skip appointments and circumvent safety procedures, resulting in additional emergency room visits and hospitalizations. When confronted with his behavior, he threatened to sue the medical center.

The CCRB reviewed the case and, at its recommendation, the Chief of Staff sent the patient a letter and health care agreement which identified a continuity-of-care provider, stipulated expectations of the patient and clarified that care would be provided only if the patient met those expectations. After signing the agreement, the patient began keeping appointments and received safe and appropriate care.

DRUG-SEEKING BEHAVIOR PROGRAM (DSB)

The Drug-seeking Behavior program is a committee that works to identify and control behavior in which patients try to influence a physician to prescribe excessive psychoactive medications or who obtain such medications through illegal activities. The committee is comprised of physicians, the director of the Medical Center's drug and alcohol treatment program, psychologists, pharmacists, nurses and the VA's attorney.

The DSB committee has three objectives:

- Identify drug-seeking behavior that may harm the patient and institution.
- Help identify primary providers for controlled medications.
- Provide continuous education related to drug-seeking behavior to clinical and administrative staff.

In order to identify drug-seeking behavior, the committee established the following criteria:

- Multiple unscheduled visits requesting controlled medications.
- Non-compliance in follow-up care plans (e.g., clinic appointments, scheduled tests and/or procedures, consults)
- Abusive or threatening behavior when denied medications.
- Multiple excuses of lost, stolen or damaged medications.
- Alteration or forgery of prescriptions.
- Use of fraudulent records to obtain medications (e.g., false identification or medical records).
- Pursuing care simultaneously from multiple providers (VA and/or Community).

How It Works

When a health care provider identifies drug-seeking behavior, the patient's case is referred to the DSB Committee for review. After reviewing the case, the Committee identifies a single provider for prescriptions.

The Committee then notifies all current providers for the patient via memo that a problem has been identified with the patient's use of controlled substances. The notice also states that a single provider has been identified to do all prescribing of controlled substances for this patient. An electronic flag is placed in patient records which alerts all providers when the patient requests care. Findings of the DSB Committee are not formally communicated to the patient. However, if the patient asks, the facts are reviewed, including steps that could be taken to have the label removed. The label can be removed via an appeal process to the DSB Committee.

Portland VAMC Results

The Drug-seeking Behavior program has achieved substantial results, including:

- Reduced potential for iatrogenic addiction.
- Increased awareness of appropriate prescribing practices.
- Fewer unscheduled patient visits for controlled medications.
- Patients referred for pain management and substance abuse treatment.
- Enhanced primary providers' role in caring for patients with drug-seeking behavior.
- Strong administrative and district counsel support for management of patients with drug-seeking behavior.

CASE STUDY — DSB IN ACTION

A 60-year-old male veteran with prostate cancer was receiving care from several different subspecialty clinics at the VA Medical Center. Through these clinics the patient obtained one type of oral narcotices for pain management from three different clinic providers. When the patient develped increased pain as a result of cancer spreading throughout the body, he obtained a second additional oral narcotic by two of the clinic providers. The patient was found to be using one of the narcotics and selling the second.

After review, the DSB Committee helped clinic providers select a single provider to monitor patient's pain and prescribe effective narcotic analgesia, thus providing safe and appropriate care while reducing unscheduled visits for narcotics and drug diversion.

BEHAVIORAL EMERGENCY COMMITTEE (BEC)

The Behavioral Emergency Committee's purpose is to increase safety for both staff and patients in the Medical Center. It identifies conditions contributing to patient violence, identifies patients at high risk for violence, provides a computerized warning system for staff in dealing with high-risk patients, and trains staff in preventing and managing dangerous behavior. Additionally, it fills a policy-making and review role regarding issues surrounding dangerous behavior.

The BEC's objectives are to:

- Provide data and recommendations for policy-making and review.
- Increase staff confidence and reduce stress levels in dealing with dangerous behavior.
- Conduct and publish research in the area of dangerous behavior.
- Maintain a computer system to warn staff when high-risk patients visit the Medical Center.
- Review programs and the facility's physical design for dangerous behavior management.

How the BEC Works

The BEC is comprised of staff members from various disciplines and services — medical and psychiatric, clinical and administrative, management and line staff. The committee meets monthly, and various members fulfill assignments between meetings. The committee's functions include:

1. **Incident tracking:** Through a tested, consistent, and widespread reporting system, the BEC maintains data with which to formulate policy and procedure, change training, and place "flags" in the Medical Center's computer system for high-risk patients.

2. **Staff training:** The committee sponsors and monitors monthly workshops for any staff who desire training in managing dangerous behavior. The workshops are eight hours in length, and consist of instruction in verbal and physical intervention skills, teamwork, and self-protection. The workshops are evaluated on an ongoing basis, and CEU's are offered for nursing staff.

3. **Policy development and review:** BEC reviews Medical Center policy and procedure and recommends new approaches or revisions as necessary. This is based on the incident tracking system and the experience of BEC members. Liaison is maintained with the District Counsel's staff and with the VA Central Office, as well as with a VHA group which works on these problems nationally.

BEC-Portland VAMC Results

Incidents of violence have decreased markedly in the Medical Center as a result of BEC's efforts over the last ten years. In a major study (published in the Journal of the American Medical Association), violent incidents among high-risk patients were reduced by 91.6 percent, and visits to the Medical Center were reduced by 42.4 percent. Evaluation in the training program clearly documents its effectiveness in increasing staff confidence, even with no follow-up training for as much as one year. Staff morale has increased wherever training has been conducted, and the incident tracking system continues to gain credibility among staff.

The computer flagging system has prevented many incidents of violent or disruptive behavior and staff have expressed relief and gratitude for the opportunity to plan care in advance so that trouble has been avoided. Before the BEC, some patients consistently assaulted staff members on every visit. None of them have assaulted anyone in the Medical Center since.

CASE STUDY — BEC IN ACTION

A 47-year-old, 40 percent service-connected Viet Nam combat veteran is seen in the Mental Health Clinic for Post-traumatic Stress Syndrome (PTSD). When first seen, he disrupted the entire Clinic with loud and profane language, threatened his therapist, and brought a concealed handgun into the Outpatient Clinic on several occasions. He eventually came to the attention of the BEC through a Police Report and a staff member's submitting a Dangerous Behavior Report. On BEC review, alcohol dependency was added to his diagnoses, and Medical Center staff were warned that he was potentially dangerous.

The BEC placed an electronic "flag" in the computer, so that he would be searched whenever he visited. On his next MHC visit, he objected strongly to being searched and left without being seen. Two weeks later, he visited MHC, and reluctantly submitted to a search before visiting with his therapist. After a few more visits and searches, he went to the Security Office without being asked, and voluntarily submitted to the search.

Eventually, he and the Security Officer formed a positive working relationship, which facilitated his treatment in MHC. His therapist also was able to work with him more confidently. He was able to complete his treatment in MHC, whereas he had been unable to stay in therapy in multiple previous attempts.

FIND OUT HOW THE 3-D PROGRAM CAN WORK IN YOUR MEDICAL CENTER

The Portland VA Medical Center 3-D program is easily transferable to other hospitals and can be implemented quickly and with minimal disruption. If you would like more information on the program, please contact:

Ted Galey, M.D., Chief of Staff
or
Tim Martin, Administrative Assistant

Portland Veterans Administration Medical Center
P.O. Box 1034
Portland, Oregon 97207
Telephone: 503/220-8262, Ext. 7202

A Publication of:
Portland Veterans Association Medical Center

Portland VAMC • P.O. Box 1034 • Portland • OR • 97207

Attachment E

A volunteer transportation network provided by veterans for veterans.

Stops/Pick Up Points

Portland VAMC
(Hospital & OPC)

Salem
American Legion
2809 Market Street NE

Albany
T&R Truck Stop

Springfield
McDonald's Restaurant
3405 Gateway

Cottage Grove (if needed)
McDonald's Restaurant
1520 Gateway Blvd

Sutherlin
Unocal 76
1453 West Central

Roseburg
VA Medical Center
NW Garden Valley Blvd

Canyonville
Fat Harvey's Truck Stop
130 Jeffries Road

Grants Pass
K-Mart
1881 NE 7th

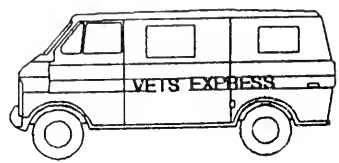
White City
VA Domiciliary

Time Table

	Arrive	Depart
Portland	9 30 AM	3 00 PM
Salem	8 40 AM	4 05 PM
Albany	8 00 AM	4 35 PM
Springfield	7 30 AM	5 15 PM
Sutherlin	6 15 AM	6 30 PM
Roseburg	6 00 AM	7 00 PM
Canyonville	5 30 AM	7 35 PM
Grants Pass	4 45 AM	8 20 PM
White City	4 00 AM	9 05 PM
	Depart	Arrive

WHO MAY RIDE

*Veterans eligible for VA transportation under Title 38 USC.
*Veterans requesting assistance due to income or physical disability.
*Veterans who do not require medical attendance or any level of medical life support equipment.
*Wheelchair accomodations are available.



WHO TO CONTACT

Eugene: Steve Thurston
465-6624

Portland: Dan Dunlap or Phil McKay
721-7804

Roseburg: Lynn Ayers
440-1293

White City: Ed Andes
826-2111 Extension 3619

PARTICIPATING ORGANIZATIONS

The following groups have worked with the U.S. Department of Veterans Affairs facilities here in Oregon to make this transportation network a reality:

- *American Ex-POW's, Dept. of Oregon
- *American Legion, Dept. of Oregon
- *AMVETS, Dept. of Oregon
- *Disabled American Vets, Dept. of Oregon
- *Oregon Elks Association, Dept. of Oregon
- *Military Order of the Purple Heart, Dept. of Oregon
- *Paralyzed Veterans of America, Dept. of Oregon
- *Veterans Rehabilitation Centers

As a result of veteran organization requests, these four VA facilities have worked to put this transportation network into place for you, the veteran. "America's Best"

VA Domiciliary, White City
VA Medical Center, Roseburg
VA Medical Center, Portland
VA Outpatient Clinic, Eugene

STATEMENT OF
BARBARA ZICAFOOSE, MSN RNCS ANP
ADULT NURSE PRACTITIONER/FEMALE VETERAN CO-COORDINATOR
& WOMEN'S HEALTH CLINIC COORDINATOR
VAMC, SALEM, Virginia
BEFORE THE
HOUSE VETERANS AFFAIRS SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS
August 3, 1994

Chairman Evans and Members of the Subcommittee:

My name is Barbara Zicafoose and I am pleased to be here today to present information on Women Veterans Health Clinics, the Day Unit, and the Primary Care Clinics in Ambulatory Care...services which have improved care to veterans at the Salem VA Medical Center. I am an Adult Nurse Practitioner assigned to the Day Unit as well as the Female Veterans Co-Coordinator and Women Veterans Health Clinic Coordinator for the Medical Center. I have been employed at the VAMC for twenty-two and a half years.

Women's Health Care Clinics

Health care delivery at the Salem VAMC has undergone several significant changes since 1991. One notable change has been the establishment of a women's preventive health screening clinic, known as the Women's Health Clinic (WHC). The staff recognized the need for a women's clinic based upon the following: increase in the number of women seeking care at our facility; the Medical Center's emphasis on providing care to all veterans; and the Veterans Health Administration (VHA) focus on equity of access, service and benefits to the growing number of women veterans. The feasibility of developing a WHC which would provide gender specific care was discussed with all levels of administration and an interdisciplinary task force was created to develop a proposal for such a clinic. The task force first met in November 1991. A program proposal was developed and approved. The clinic was established and appointments scheduled, initially giving priority to women determined at high risk based upon clinical criteria. The clinic was opened on June 28, 1992, seven months after the first planning meeting, and is currently in operation two days per week.

Resource Allocations

Recognizing the need to provide enhanced services while working within budgetary constraints, the task force worked to establish the clinic predominantly within existing resources. Physical space, equipment, and consumer-focused needs were major resource issues. The decision was made to utilize one private patient room in the newly established Day Unit as the "Women's Health Clinic" with interested staff from the Day Unit supporting the clinic. The room is assigned to the WHC twice a week and the remainder of the

time supports other outpatient services. Decorations for the clinic were donated by private individuals and service organizations. Gender-specific equipment was collected from throughout the Medical Center and centralized within the Women's Health Clinic. The WHC room has an adjoining bath, thus meeting VHA criteria of privacy for female examinations. A comfortable, quiet waiting area is provided.

The WHC is managed by Advanced Practice Nurses (APNs) with Physician liaison as indicated. An RN/LPN and Medical Administration Service (MAS) clerk support the clinic. These staff members are shared with Primary Care and the Day Unit on non-clinic days. Consultative services to interdisciplinary support are initiated on an as needed basis.

Services Provided

The WHC was designed to provide a specialized and comprehensive interdisciplinary program to assess, treat, and/or refer female veterans for such illnesses as oral, breast, cervical, and colorectal cancer; hypertension; diabetes mellitus; osteoporosis; and identification of risk factors such as hypercholesterolemia. Education regarding lifestyle changes is one component of the program.

In addition to routine screenings provided, services available include hormone replacement therapy (HRT), information on and treatment of sexually transmitted diseases (STDs), and education and counseling for sexual and physical abuse, menopause, breast self-exam (BSE), aging, sexuality, smoking cessation, nutrition, diet counseling, and exercise.

The Salem VAMC has a psychologist who specializes in sexual and/or physical abuse counseling. She is available to the WHC by consultation and on an emergency basis. There is also a support group directed by a female psychiatrist and a Clinical Nurse Specialist. The group meets weekly to help women deal with physical and mental abuse issues.

Process and Outcomes

Upon admission to the clinic, a history/data base, initial assessment, and laboratory tests (ordered by the Advanced Practice Nurse) are obtained by the RN. Further assessment and physical examination are performed by the APN, who provides appropriate consultations with other disciplines as indicated. Gynecological services needed and not available at our facility are contracted out to a local health care facility. Reports of diagnostic studies are reviewed by the APN in consultation with the Physician-Liaison

when indicated.

Specific forms, such as history and physical exam forms, log sheets, statistics sheets, and overprinted follow-up letters are used to assure appropriate documentation of care provided. Through 100 per cent follow-up by Quality Improvement (QI) indicators, we assure continuity of care and enhanced standards of care. Patient satisfaction surveys are utilized to improve services to patients and modify care provided in the clinic. The patient is notified by the APN, in writing, of all results obtained. Women attending the clinic have repeatedly commented on how pleasurable it is to attend a clinic which recognizes their gender-specific needs and concerns.

Primary Care Team for Women

An outgrowth of the WHC has been the development of a Primary Care Team for Women (PCT/Women). While the WHC provides preventive health screening, the PCT/Women provides comprehensive managed care of acute and chronic medical problems. This clinic opened in January 1994 and is managed by an Advanced Practice Nurse with Physician liaison. This clinic is in operation one day per week and like the WHC was established utilizing existing resources. Individual verbal and written evaluations reveal that patients are very satisfied with care provided in our Women's Health Care Clinics.

Other Innovative Programs for Enhanced Care

Salem VAMC's Day Unit

Two and one-half years ago, recognizing the trend in health care toward outpatient services as a means of providing improved care to increased numbers of individuals in a cost-effective manner, Salem initiated a unique delivery of care model called the Day Unit. The Day Unit is an outpatient ambulatory clinic offering diagnostic, treatment, and preventive health services. Open Monday through Friday from 6:00 AM to 6:00 PM, the Day Unit provides services for surgical, medical, and psychiatric patients of all ages.

Transcending the traditional hospital philosophy which encourages "inpatient" versus "outpatient" access, Salem's Day Unit provides a creative response to this critical aspect in the patient's overall treatment plan by providing coordinated, comprehensive care, evaluation, and education in a timely, cost-effective manner.

The Day Unit was established strictly within existing resources and utilizes an interdisciplinary team approach to patient care similar to that used in primary care. It is a Nurse Administered unit with Advanced Practice Nurses serving as primary care providers for both

outpatients and inpatients. Collaboration with physicians admitting the patients to the Day Unit is ongoing and care provided is patient centered and outcome oriented. The Day Unit Staff consists of APNs, registered nurses, licensed practical nurses, and other supportive staff.

An array of services is available through the Day Unit, including ambulatory surgery, medical procedures, diagnostic medical work-ups, risk stratification for surgical patients, monitored cardiac catheter recovery, emergency consultation, patient/family education, and preventive health services. Seventy-three percent of all Salem's surgeries are currently performed through the Day Unit on an outpatient or Same Day Admission basis. Management costs for labile diabetes patients have been reduced by sixty percent since initiation of outpatient treatment in the Day Unit as opposed to the previous treatment modality of inpatient admission to the hospital.

The Day Unit Delivery Model improves quality of care through improved access to diagnostic, treatment and preventive health services at an appropriate and cost-effective level of care in the Ambulatory Care setting. It allows consistent care by the primary care provider using the APN as part of the primary care team while a patient is in the Day Unit. Additionally, the model saves money for the Medical Center and provides a setting for focused research and education for primary care providers (MD, APN, PA). The flexibility of the Day Unit allows for the development and initiation of clinics managed by APN, including (but not limited to) a Women's Health Clinic and a Dermal Wound Care Clinic. It also provides the structure by which patient populations are being case managed.

Primary Care Clinics

In 1991, at the same time that the Day Unit was established, a restructuring of the ambulatory care section was occurring. Administrative and clinical staff recognized the need of developing a managed care system for the outpatient section and as a result of collaborative team work, "Primary Care" within the Ambulatory Care Clinics was implemented. The ambulatory care staff was divided into teams, utilizing the interdisciplinary team approach to patient care. Every patient was assigned to a specific team. Now the patient's health-care experience is managed by "his/her Primary Care Team".

The essence of our primary care teams is to promote optimal functioning for each patient on a longitudinal basis within a

managed care system. Each team provides initial and continuous evaluation, risk stratification, education, on-going follow-up, counseling, referrals and an array of other specialty services to a diverse patient population with complex needs. In addition, selected team members follow their patients during each hospital admission. Patient care by the primary care team is resumed upon discharge from the hospital. Thus, patients receive consistent care by the same primary providers each time that care is needed.

Primary Care Teams (PCTs) include a Physician, APN or Physicians Assistant (PA), Senior Nurse Clinician, and Medical Assistant. A Social Worker, Medical Administration Service (MAS) clerk, Psychologist, and Pharmacist are available in each area and are shared by various teams. Clinics managed by the Medical Residents with supervision by Primary Physicians are also part of the Primary Care Team. Decisions made within each team are interdisciplinary, patient centered, and outcome oriented. The Matrix Management Model for program development and enhancement, as well as staff involvement in decision making, is utilized in this Primary Managed Care model. In January 1994, the Primary Care Teams were divided into two "Firms" which consist of three Primary Care Teams each. Primary Care Teams within each Firm work collaboratively to help each other during heavy workload demands, vacations, or similar extenuating circumstances.

The concept of Primary Care Teams in the Ambulatory Care Clinics has resulted in favorable outcomes for patients and staff. Each team member and each team is patient-oriented and patient-driven. Services provided are personal, comprehensive and continuous and have resulted in the prevention or shortening of hospitalizations in many instances. There is a commitment to provide appropriate, timely and cost-effective quality care utilizing the interdisciplinary team approach. Access to the usual health care provider for intercurrent problems, such as the ability to see or talk to "my doctor", "my nurse practitioner", or "my nurse" between scheduled appointments, has been greatly enhanced. A special bond exists between patient and provider, something not so easily recognized before "primary care teams". The patients get to know their team members well and reciprocally, the staff have a specific patient caseload with which they become familiar. The result is continuity of care for the veteran, improved communication within each team, expeditious access to subspecialty consultation, additional testing when indicated, and increased accountability by all levels of staff on the Primary Care Team. Patients receive regular, holistic, managed care by health care providers with whom they are familiar and with whom they have confidence, while at the same time reducing unnecessary enrollment

in subspecialty clinics. With this Primary Care Delivery Model, fragmentation of care has become non-existent.

Other Program and Activities

Many other innovative programs have recently been or will be initiated this year at the Salem VAMC. In October 1993, a nonservice-connected Primary Care Clinic was opened to care for pensioned, low income, and/or homeless veterans. In May 1994, the Medical-Surgical Subspeciality Clinics were restructured into the team format patterned after the Primary Care Teams and Psychiatric Primary Care Teams have recently been implemented. A Preventive Health and Improvement Clinic is slated to open in September. All of these programs were developed within current budget constraints and shifting of existing resources from inpatient to outpatient areas. Staff selection for these outpatient programs was based upon clinical experience, high levels of competency, previously demonstrated creativity, and ability to work collaboratively with others.

Summary

Since 1991, the Salem VAMC has initiated several programs which have significantly impacted on care and available services to veterans. The Women's Health Care Clinics, the Day Unit, and Primary Care Teams all use an interdisciplinary approach to provide comprehensive, managed care to patients in varied settings. Ongoing screening, counseling, and education are provided in an accessible, coordinated, and sensitive manner. With members of the interdisciplinary team working with the veteran as partners in managed care, disease prevention, and health maintenance, we are giving veterans an opportunity for a longer, healthier future.

" A Center of Excellence for Women's Health"

Advancing Women's Health through Women's Health Care Clinics

Veterans Affairs Medical Center
Salem, Virginia

Knowing the Facts

Services We Provide

Comprehensive Health Care and Screening

Pap Smears
Pelvic Exams
Breast Exams
Mammography
Colorectal Cancer
Hypertension
Cholesterol
Oral Screening
Diabetes
Osteoporosis
Coronary Artery Disease
Acute/Chronic Medical Problems
Hormone Replacement Therapy
Contraception
PMS
Sexually Transmitted Disease

Education, Counseling and Support Groups

Sexual and Physical Abuse
Menopause
Breast Self -Exam
Aging
Sexuality
Nutrition
Smoking Cessation
Diet Counseling
Exercise

Clinic Location

Women's Health Care Clinics

Building 143
Second Floor

For appointments and additional information contact:

Women's Clinic
Monday - Friday
6 A.M. - 6 P.M.

Please call 982-2463 Ext. 2152/2153

Female Veterans Co-Coordinators

Margaret Skelly, MSW
982-2463 Ext 2526

Barbara Zicafoose, RNCS, MSN, ANP
982-2463 Ext 2030

Eligibility

You are eligible for services if you...

* Are a veteran of the U.S. Army, Navy, Air Force, Marine Corps or Coast Guard.

* Served in the Women's Army Auxiliary Corps (WAAC) in 1942-43.

* Flew as a Woman's Airforce Service Pilot (WASP) in 1942-43.

* Were a telephone operator, clerk, dietitian or reconstruction aide with the Army in Europe during World War I .

Your Clinic Staff

Barbara Zicafoose, RNCS, MSN, ANP
Christina Stephenson, RNCS, MSN, FNP
Patricia Mikes, RNCS, MS, ANP
Ruby Thompson, RN
Jean Hardy, RN
Doug Lienesch, M D

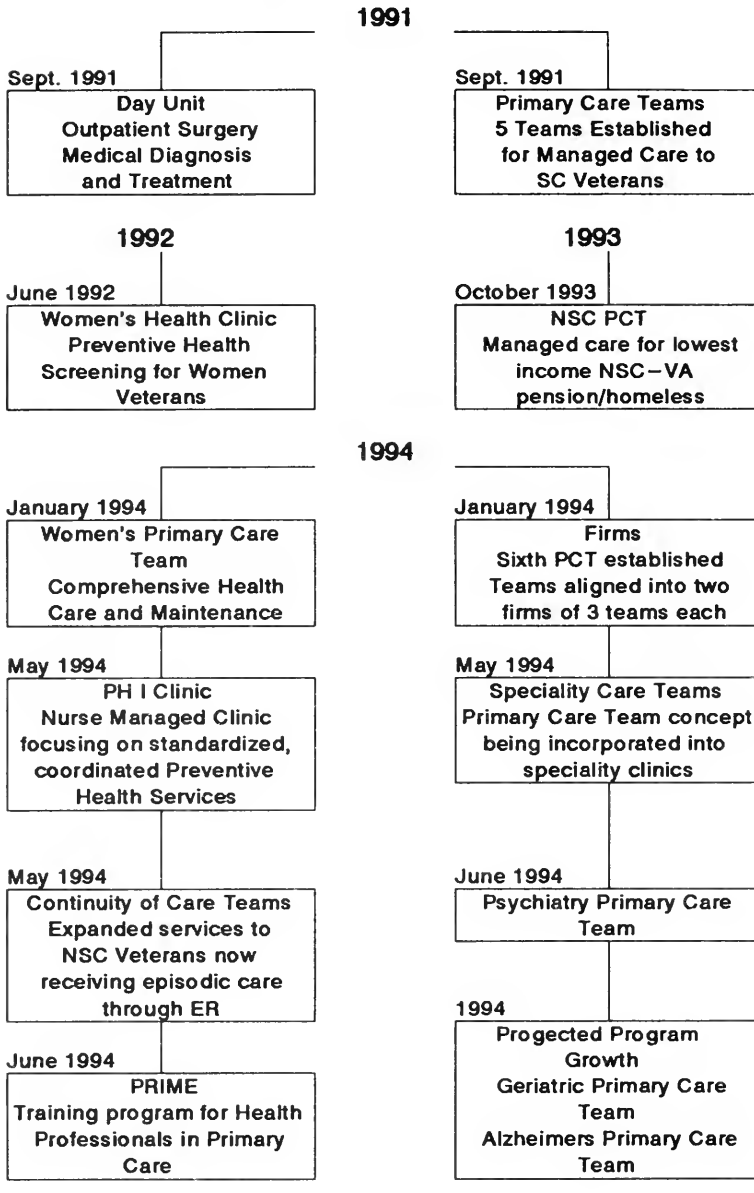
We are the Nurses in Advanced Practice and staff providing specialized care. We offer health screening, education , treatment and or prevention of disease for all women veterans. Our emphasis is health promotion and Comprehensive Care for Women!

" Your Comprehensive Health Care is Why We Are Here"

Did You Know?

- 1 in 9 Women will get Breast Cancer
  The Good News: Nearly 9 out of 10 women could survive
- Lung Cancer is the Leading Killer of Women
  The Good News: 40,000 Women can be saved each year
- 77,000 new cases of Colon and Rectal Cancer each year
  The Good News: Finding out early can save 3 out of 4 individuals
- Osteoporosis usually goes unnoticed until a bone is broken
  The Good News: Treatment with hormone replacement therapy can delay bone loss and prevent fractures
- Nearly 2,600 women die each year from Melanoma, a serious skin cancer
  The Good News: Most Skin Cancers can be cured

Leading In A Time Of Change
Salem VAMC's Unique Primary Care Models



STATEMENT OF
KAREN WALENGA,RN
ASSOCIATE CHIEF, NURSING SERVICE, EXTENDED CARE
DEPARTMENT OF VETERANS AFFAIRS
CARL T. HAYDEN VA MEDICAL CENTER
PHOENIX, ARIZONA
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE COMMITTEE ON VETERANS' AFFAIRS

VA USE OF EMPLOYEES AS VOLUNTEERS IN PROVIDING CARE TO VETERANS
AUGUST 3, 1994

Mr. Chairman and members of the Committee,

Thank you for the opportunity to appear before you today to present testimony on and demonstrate how the Department of Veterans Affairs (VA) is using employees to care for our veteran patients.

In the Spring of 1989, the 120 bed nursing home care unit of the Veterans' Medical Center, Phoenix, AZ., experienced an acute rise in patients requiring total nursing care. Along with multiple other functional losses, 25% of the population required total feeding with another 50% needing tray preparation and encouragement to self feed. Managerial attempts to handle the increased demand through, a) staggering of tray delivery times; b) alteration of work schedules to concentrate staff at meal time and c) attempts to recruit individuals through Volunteer Service brought insufficient relief with individual nursing staff still trying to manage the feeding of three or four patients at mealtime. Due to time constraints and numbers of patients it was distressing to note that the staff began grouping patients and hurrying between them with little social interaction occurring.

Functionally impaired, but otherwise cogitatively intact patients were acutely aware of the dilemma and felt a need to hurry at mealtime. The obvious solution, more staff, was not possible due to the reality of fiscal constraints.

The idea for the "Breakfast Club" was born one hectic noon meal in June 1989. As supervisor for the nursing home care unit, I found myself simultaneously resolving a priority issue with an employee from another department while assisting patients with meal set-up and feeding. While engaged in conversation, fueled by the frustration of

the moment, I spontaneously asked the individual to pick up a spoon and help the patient next to him. His response, sparked the idea. Hesitant at first, he picked up the spoon and then stated, "I had no idea that you needed this kind of help...it really isn't so hard to do....maybe I could help again sometime." Idea: why not ask medical center employees to volunteer some time before work, or after work to help feed nursing home patients? Caring, motivated people exist in every organization particularly health care facilities. Many volunteer in multiple community agencies. Could we tap into this resource and encourage employees to volunteer "on site"?

The answer was "Yes" growing from a small nucleus of eleven employees to ninety within the first year. The phenomenal response to the program is attributed to the following actions taken prior to and during the initiation of the program:

a) Gain Top Management Support - Explanation of need resulted in commitment of Volunteer Service and Medical Media support along with personal involvement of the Medical Center Director and Chief of Staff in the feeding program.

b) Publicity - Getting the word out to employees - adopted a Breakfast Club logo, locally designed, with Medical Center recognition. Flyers, posters, badges, CCTV, newsletters, staff meetings, and word-of-mouth were utilized to recruit participants.

c) Start Small - Asked employees to volunteer one hour, once a month, to feed a nursing home patient.

d) Recruited Volunteer Coordinator - Probable secret to volume of participation and longevity of program. Individual knows patients, staff and volunteers. Coordinator facilitates scheduling, personal preferences, provides positive reinforcement to participants, problem solves, and maintains lines of communication.

e) Nursing Staff Support - Nurses welcome volunteers, are available for questions, and are appreciative of volunteer effort.

f) Flexibility - Program open to suggestions from volunteers. If individuals felt complete feeding was overwhelming, help by preparing trays, socializing during meals. Incorporated talents brought and then offered by employees in other areas - walking patients,

visitation, gardening, hair dressing. This increased personal ownership in program.

g) Recognition - In order to recognize "Volunteer" employees and increase staff awareness buttons with "Breakfast Club" logo are worn by participants. An annual breakfast and certificates of appreciation builds morale. Medical Center employee awareness of contributions of individual volunteers fostered through pictures and personal accounts in medical center newsletter.

Publicity and top management personal commitment lead to interest and curiosity from various veteran service organizations. Discussion with these organizations resulted in them providing "hands on" help at the noon and evening meal where employee volunteerism was low. As a result the "Let's Do Lunch" bunch and "Guess Who's Coming to Dinner" volunteers were established.

The costs of the employee feeding time have been minimal in comparison to its benefits. Purchasing lapel buttons and an annual recognition ceremony are the monetary costs. The patients in the nursing home care unit reap multiple psychosocial and quality of life benefits. Their otherwise closed community is opened up to a variety of volunteers who provide service, friendship, caring and a tie to the outside community. Mealtime becomes "special" with increased socialization, and food intake; sometimes accompanied by decreased confusion and increased desire for personal grooming. The mingling of employee/patient in a personal bond increases patient satisfaction and may result in a more inspired, informed and involved workplace.

Disciples of the highly successful patient/staff volunteer program at the Phoenix VA Medical Center exported the idea to other VA's and private sector agencies. Through national telephone hotlines, participation in national/local workshops and poster presentations the work spread. Approximately, fifty VA's to date have requested information in order to institute their own employee volunteer program.

You've seen the movie...

...now join the cast

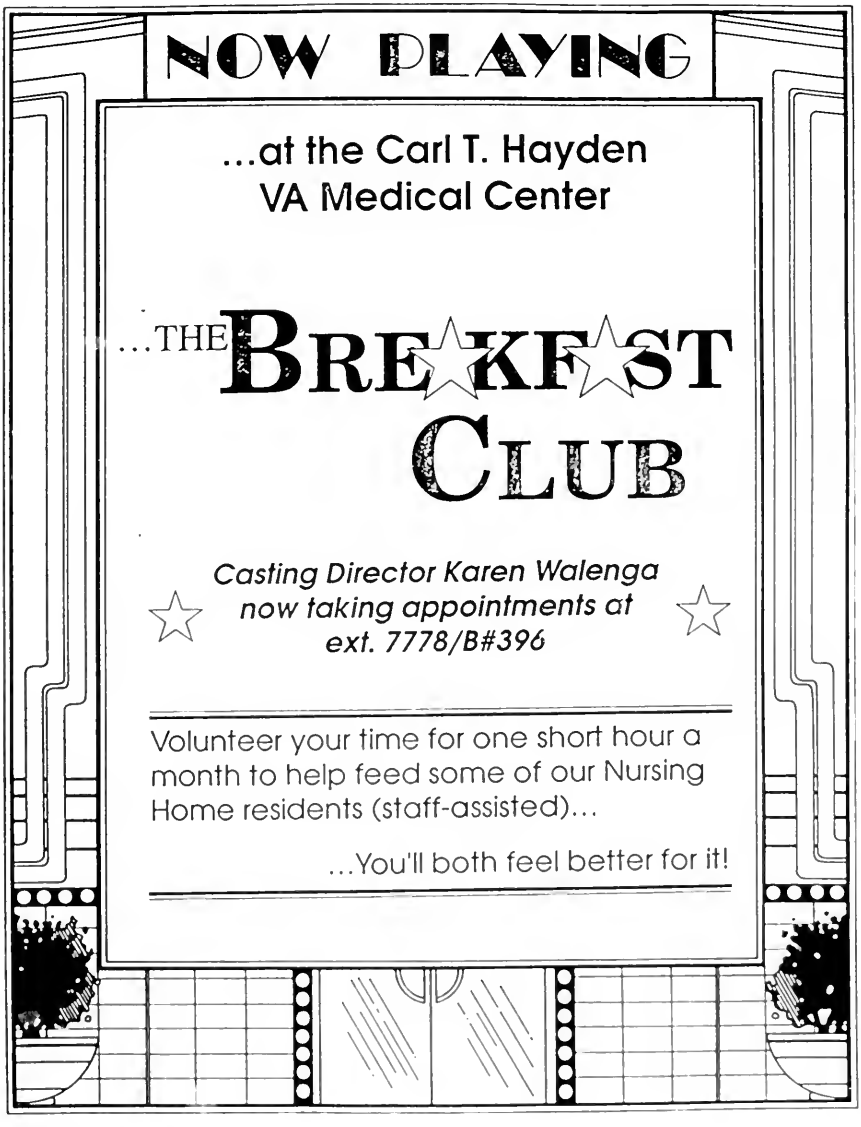
...THE BREAKFAST CLUB

Casting Director Karen Walenga now taking appointments at ext. 7778/B#396

Volunteer your time for one short hour a month to help feed some of our Nursing Home residents (staff-assisted)...

...You'll both feel better for it!

VA Voluntary Service • Carl T. Hayden VA Medical Center • Phoenix, Arizona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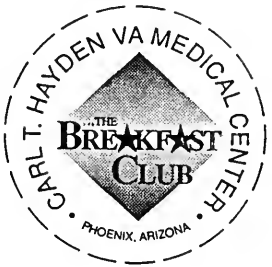

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THE BREAKFAST CLUB
Department of Veterans Affairs
THE BREAKFAST CLUB
MORE INFORMATION

OPPORTUNITY
PROMOTION
TIPS
IDEA
HELPERS
COORDINATOR
IT WILL GROW!
RECOGNITION
Let's Do Lunch!
Guess who's coming to dinner

Congressional Testimony
Presented on August 3, 1994
to the Congressional Subcommittee
"Improving Services to Veterans: Initiatives and Innovations in the Department of Veteran Affairs"
Submitted by:
Jim Bradford
Vocational Rehabilitation Therapist
Registered Horticulture Therapist
Veterans Affairs Medical Center, Long Beach, CA.

Written Testimony

I am pleased to have the opportunity to address this subcommittee on "Improving Services to Veterans; Initiatives and Innovations in the Department of Veteran Affairs."

I am a Vocational Rehabilitation Therapist and a Registered Horticulture Therapist at the V.A. Medical Center in Long Beach, CA. To provide this subcommittee a perspective on what has occurred at the Medical Center in Long Beach, I will recount the events that relate to this issue. In 1978 there was a need to treat patients in an outdoor program that offered work to help them recover and return to the job market. This program needed to offer hands-on activities that would relate to and translate into real jobs. The decision to rejuvenate a small corner of the grounds into a garden area, like it had been in the 1940's, was adopted. The area had one storage building and the remains of a Navy brig. The renovation also needed to fit another criteria, it had to be done economically. I asked if I could take on the challenge. Over the years it has been transformed into a beautiful, functional farm, with great earning potential and at minimal monetary outlay of V.A. funds.

In 1980 I was able to get enough excess cement to pour wide sidewalks between raised garden beds that we had constructed with donated lumber. This served to accommodate our first wheelchair patients. This philosophy of utilizing donated supplies and equipment was the cornerstone of the project. I am the only paid hospital employee in our horticulture program, so I have assembled a team of volunteers that are knowledgeable in gardening and devoted to helping patients. Our patients are assigned to willing volunteers that help coordinate a team approach. This technique successfully enables our patients to receive instruction on each specific task.

The project garden could only survive if it could produce enough to pay its way. The first few years were spent in just rebuilding the soil to become plant worthy. Patients loved moving compost and straw to improve the potential of the garden. After our greenhouse was donated to the hospital in 1989, from the California Women's Bowling League, we pushed into gear our plan to pay patients that otherwise might not be able to find work. This offered the year round component of growing a crop for profit. Growing poinsettias in the time from September to December and growing our spring vegetables for planting and sale from January to August, enabled us to propagate plants for resale all year and pay our veterans.

The need to provide services on a contract basis arose, first in our chapel. This was met by training patients to care for interior plants and paying them while they learned. Fresh flowers were easily sold on contract and patients would prepare garden grown flowers to fill vases in a local restaurant on a weekly basis for pay. The contracts generate a source of income for the patients during times when there are no crops ready for sale.

The need to upgrade waiting rooms in the hospital was met with another contract. The hospital is trying to make waiting rooms more peaceful and soft with the use of plants. This offers a sanctuary for ill patients to relax while waiting for treatment. The new radiation building, scheduled to open in August, will feature a waiting room with a full complement of plants. These will be installed and maintained by our patients, practicing job skills.

The Medical Center Director, in 1988, was motivated to improve the garden beds at the Medical Center entrance. He mentioned that it could be a patient project and asked if we were interested in planting and maintaining them. This was gladly taken on as a duty because it offered a great display area for flower bed design. Patients could learn and take pride in making the front of the hospital a focal point. It has been planted over and over using donated plants.

In our main patio area, another planting project was offered to us, the Blue Star National Monument. This too, became a perfect learning bed, teaching patients how to design, lay out and plant outdoor beds with available donated plants. These two areas accomplish two important goals. First, it gives us an excellent place to train patients in planting, and secondly, it beautifies

the hospital and saves money at the same time

Many of our patients who have lost the use of an extremity need to be provided training in the use of a wide variety of adaptive gardening tools Our quadriplegic patients (those that are unable to move their arms and legs) have provided me the opportunity to make many adaptations to the bird beak mouth stick This allows them to plant our seeds using only their mouth These patients are typically high level spinal cord injuries that require respirators to breathe By using a mouth piece that they can bite on and a button that they can depress with their tongue these patients can pick up seeds and place them in flats This allows them to become an integral part of the garden team by planting the seeds. (SEE COVER)

I joined the American Horticulture Therapy Association knowing that they had compiled a list of many adaptive tools Utilizing their list and adding to it with the ones that I had made I have been able to show veterans the state-of-the-art tools available to compensate for loss of functional extremities, or pain in certain positions I am presently Vice President of the Golden West Chapter of the American Horticulture Therapy Association. I utilize this capacity to teach volunteer groups, high school students, and senior groups about the benefits of Horticulture Therapy As guests of the Tucson, Arizona Men's Garden Club, several members of our chapter recently traveled to Tucson to give a free seminar at the Arboretum

I became aware that our veterans in the Nursing Home Care Unit needed more sensory stimulation Through the effective use of team volunteers, who pushed wheelchairs, many of the previously nursing home bound veterans are transported to the garden While there, they are able to observe the gardening activities and pick flowers This garden outing is conducted one day each week and has become immensely popular The flowers are taken back to the dining area and a bud vase for each table is filled with fresh flowers by the patients This has improved the ability of the patients to interact with each other and provides an atmosphere conducive to the sensory needs of hospital bound patients This one act improved the number of patients that come out of their rooms to eat in the central dining area by 40%. They no longer choose to receive food in their rooms and have begun to interact with other patients, simply because of the flowers

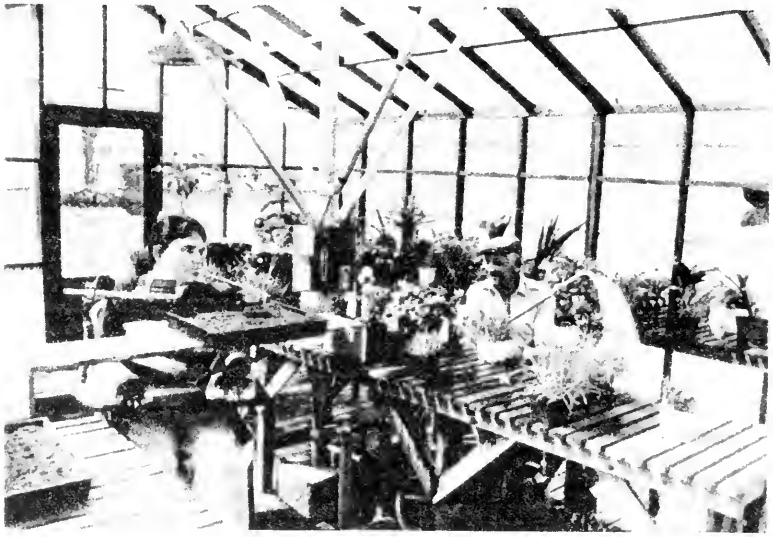
Two other programs within our Vocational Rehabilitation Program that I feel deserve mention here due to the improvement they have made in services to the veteran are the Computer Training Programs and our Job Club In 1991 the need to offer our veterans computer training became obvious We transformed two clinics that had become antiquated a black and white photography and electronics clinic, into a state-of-the-art computer training clinic We linked up with a club in Long Beach called the I B M Users Club whose members offered to assist in helping teach computer skills Beginning with one donated old computer, it quickly grew when the Jewish War Veterans donated 10 new I B M computers and printers Since then, we have added 10 more computers and printers, all donated by veterans service organizations This quickly became a very popular clinic with approximately 1,400 veterans per year receiving an introduction to computers through this program This computer popularity, combined with the need of our unemployed veterans to become computer literate, and therefore more employable, motivated us to start our Computer Applications/Office Assistant Training Program in 1993 This program trains selected veterans in most major software programs, over a period of three months in a highly structured classroom setting Since the inception of this program, 62% of the graduates have become employed within four months

Another clinic which has improved our service to veterans is our Job Club In the Job Club the patients learn job application techniques, resume preparation, job presentation skills, and job survival skills Although we have a large patient load of substance abuse and homeless patients who are difficult to place, 60% have become employed within three months of discharge We are currently treating approximately 50 patients per month in the Job Club

Recently the Job Club has become so successful that the demand caused us in 1994 to add a second Job Club to serve the out patients needing help The unemployment in California being very high, makes it difficult to place veterans with a history of psychiatric and/or medical problems The Job Club trains them in job seeking skills necessary to become competitive in the

employment field. This program currently serves approximately 40 patients per month.

I want to thank you for giving me the opportunity to present these programs to you. I sincerely believe that these really meet a need and have been implemented for a nominal cost, and, at the same time, provide excellent therapy for our veterans.



John E. Mullaney
Medical Equipment Repairer
Edward Hines, Jr., VA Hospital
Department of Veterans Affairs
Hines, Ilinois

August 3, 1994

ENVIRONMENTAL SYSTEMS FOR DISABLED HOSPITALIZED VETERANS

Mr. Chairman, and Members of the Comrittee, I am pleased to be here today to testify before this committee. In 1985, I began noticing that many of our older spinal cord injury residents were regressing in their ability to turn on and change the channels of their TV sets without assistance from the nursing staff. Many of them were already totally dependent on staff for all their activities of daily living. This problem was becoming time consuming and very frustrating for both the residents and the staff as well.

I designed and developed a proto-type box for use by high quadriplegics that could be accessed by blowing into a straw to perform three various functions: (1) Turn ON the TV; (2) change channels; (3) access the nurse call system.

After demonstrating the unit, I was told that funding for such a project would have to come from the private sector. A Service Officer from the Rotary was very receptive of my idea and helped raise enough moneys to have the "boxes" built by a private manufacturer. I provided this manufacturer with the overall technical information that I had formulated along with the proto-type that I had built. With this information, he was able to provide a final product for our customers.

A total of fifty (50) units were purchased at a cost of $400/ea. and were utilized by our veterans in the main hospital during the time that Hines VA Hospital was in the planning stage for the first free-standing Residential Care Facility for Spinal Cord Injury veterans within the VA system.

After convincing the Hospital Director of my new idea to incorporate an individual 9" color TV on a "C" arm type bracket for each resident room, the Director agreed that the cost savings in man-hours and the ability of increasing the veteran's self esteem was worth investing in. Not only would this device save staff time, but it would give the completely paralyzed residents a realization of freedom by enabling them to be in control by selecting various functions on this device. I have attached a copy of a newspaper article that pictures the units so that members of the committee can see what the finished product looks like. As you can see, the TV can be moved out of the way for emergency care of the veteran (e.g., cardiac arrest, pulmonary seizures, etc.)

On behalf of the disabled veterans I am honored to serve, I would like to thank the Committee for this opportunity to present my testimony on what I believe is an invaluable tool of independence. Mr. Chairman, this concludes my formal statement. I will be pleased to answer any questions you or the committee may have.

Attachment

SOMEONE YOU SHOULD KNOW

An inventor and 'Jack' of all trades

By Sandra Wilcox
Long Term Care

Those who don't know **John "Jack" E. Mullaney** would probably be surprised that he helped develop the concept and prototype for sip and puff. The sip and puff apparatus allows quadriplegic/paraplegic veterans the ability to turn on and change channels on a bedside television. It has been adapted to bedside telephones and motorized wheelchairs to give the paralyzed veteran much more independence. The private sector has borrowed the sip and puff idea after seeing how well it works here.

Mullaney developed saliva ejectors for the blow tubes which operate the apparatus. When you see patients operating wheelchairs with only a tube in their mouths, you know a fellow Hines employee was involved in the invention.

When he's not tinkering with new ideas, Mullaney does anything required of an employee of the Biomedical Engineering Section. Working primarily with Spinal Cord Injury Service in the Extended Care Center and Residential Care Facility, he does maintenance and repair of special beds, nurse calls and preventative maintenance on wheelchairs.

Long before he became a graduate electronics technician of DeVry, Mullaney was working as an aircraft and engine mechanic in the Air Force. He spent a year and a half in Korea, and is a life member of the Amvets. He and his wife of 35 years have two adult children. A member of the Moose for 16 years, he is now Governor of the lodge, and was nominated Moose of the year in 1991. That same year, Mullaney was nominated for Federal Employee of the year by Hines.

The next time you want to meet someone interesting, look up this "Jack of all trades"!

Photo by Pam Gallicho

Jack Mullaney helps patient **Robert Blaskovitz** use the sip-and-puff apparatus to change channels on his TV

HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT
AND INVESTIGATIONS, HVAC, AUGUST 3, 1994

MARY-ELLEN PICHE', CONTINUOUS QUALITY IMPROVEMENT COORDINATOR

SAMUEL S. STRATTON VA MEDICAL CENTER, ALBANY, NEW YORK

The Samuel S. Stratton VA Medical Center is a 540 bed facility that provides comprehensive tertiary medical, surgical, psychiatric, neurological and long-term care, serving approximately 190,000 veterans. Primary care outpatient services are provided with a broad range of preventive services, specialty clinics and emergency room services. It maintains an affiliation with Albany Medical College.

Management and employees at all levels of the organization began approximately four years age to implement a continuous quality improvement(CQI) model, designed to improve customer service and create an environment which supports innovation. Leadership, employee involvement and teamwork are the hallmarks of our CQI program. Operational elements include cross-functional process improvement teams, an automated employee suggestion program, patient/employee feedback systems and ongoing assessment and strategic planning activities.

More than sixty cross-functional teams have successfully improved the processes of healthcare delivery to our veteran patients. Physicians, nurses and lab technologists, together with a ward clerk and a volunteer, improved the processes of ordering, procuring and analyzing sputum specimens resulting in a significant decrease in the rate of unsatisfactory sputum specimens. A multidisciplinary team developed a clinical pathway for patients undergoing total hip replacement surgery. By designing a

coordinated plan for pre-operative assessment, in-hospital care and post discharge follow-up, the team improved patient/staff satisfaction, reduced the in-hospital average length of stay(14.5 days to 8.5 days) and improved patients' functional status. Other teams are currently working on clinical pathways for patients with diagnoses such as congestive heart failure, pneumonia and head/neck cancers.

Additional examples of employee and patient teams which have focused on improving and redesigning key clinical and administrative processes include the following:

Emergency Lab Orders Team: Streamlined the lab ordering process in the ER to reduce patient waiting time.

Operating Room Cancellation Team: Designed a patient pre-admission assessment process thereby reducing the rate of OR procedure cancellations.

Discharge Planning Team: Redesigned the process for providing medications to patients at discharge, significantly reducing the rate of medication errors and improving patient/staff satisfaction.

7D Patient Follow-up Team: Established a patient follow-up telephone call system to prevent serious complications through early interventions for patients discharged from the short-stay ward.

Clozaril Treatment Team: Designed a monitoring system to evaluate the efficacy and adverse effects on psychiatric patients receiving clozaril. Mechanisms to provide structure, support and

care during rehab and recovery were implemented.

Ambulatory Care Microbiology Reports Team: Improved the timeliness of reporting outpatient lab test results.

Home Glucose Testing Team: Established an outpatient glucometer clinic for patients who use blood glucose meters at home.

Day Treatment Center Team: Improved daily attendance by involving patients in their own treatment plan and course.

Post-op Pain Management Team: Analyzed and improved the process of post-op pain management for patients in the Surgical Intensive Care Unit.

468 Code Team: Implemented procedures to reduce staff and patient injuries during episodes of psychiatric patient aggressive behavior. Designed an assessment process to identify and treat patients at risk for aggressive behavior outbreaks.

Lab Phlebotomy Team: Designed a phlebotomy reception area which eliminated patient waits and provided a more customer focused approach to obtaining blood samples.

Partners In Practice Team: Redesigned the delivery of nursing care in the Operating Room by eliminating the charge nurse position, providing cross training opportunities for all staff and assigning the responsibility for scheduling to the staff. Results include improved customer/staff satisfaction and decreased sick time usage.

In addition to employee process improvement and redesign

teams, several mechanisms are in place to obtain employee and patient input and feedback . We automated our **Employee Suggestion Program**, allowing direct input of suggestions from any computer terminal. It is now among the top 10 most productive suggestion programs in the VA. Everyone is invited to contribute ideas at the quarterly Open Forum with top management. A popular graffiti board outside the cafeteria allows employees to share their suggestions and work values formally and more directly with fellow employees. Values identified by our employees as most important for achieving our mission include innovation, excellence, teamwork, compassion and quality.

Employees created the first **Patient Representative Steering Committee** within the VA to analyze patient feedback and guide patient-care policy. The Steering Committee provides case managers for patients with special needs. Surveys of both internal and external customers are used to identify areas for improvement. All employees are encouraged to attempt to resolve patient concerns at the lowest level possible.

Initiatives to redesign the structural and programmatic components of health care delivery include the following:

Planetree Unit: A patient and family-centered rehabilitation ward in a home-like environment offering a holistic approach to care. Patients and families partner with healthcare providers in their care. This involvement and setting creates an atmosphere

that promotes healing.

Short Stay Ward: Developed to provide focused services to patients having minor surgeries, invasive diagnostic procedures and short term therapies. Results include decreased length of in-hospital stay and improved patient satisfaction.

Fisher House: The first ever donated to the VA by the Fisher Foundation, it will provide housing for families of hospitalized patients and a home-like environment for veterans. Currently under construction, the Fisher House will open in September, 1994.

Management and staff have developed strategic and operational plans for deploying CQI throughout the Medical Center. A self-assessment instrument is used as a tool for measuring progress and identifying strategic direction. Ideas for quality improvement come from a variety of sources including patients, staff, volunteers, annual assessments and quality management data. A cadre of trainers and facilitators exists to support employee driven CQI teams and improvement activities. The common goal is to use CQI principles and practices to provide a high level of quality health care and related support services to our nation's veterans.

Testimony before the

U. S. HOUSE of REPRESENTATIVES
Veterans Affairs Subcommittee
on
Oversight and Investigations

Public Hearing on

"Improving Services to Veterans: Initiatives
and Innovations in the Department of
Veterans Affairs"

August 3, 1994

Statement by

Penny G. Hust, RNCS, CNAA
Associate Chief, Nursing Service for Psychiatry
Veterans Affairs Medical Center
Tuscaloosa, Alabama

Thank you Mr Chairman members of the subcommittee, and staff for inviting the Tuscaloosa Department of Veterans Affairs Medical Center to come before you and share our vision, initiatives and innovations in providing quality health care in partnership with our customers--veterans their families employees volunteers and our community The Health Care Reform transformation coupled with "Reinventing Government" requires a revolutionary change in leadership style Tuscaloosa Department of Veterans Affairs Medical Center began that transformation in 1989 by embracing the concepts of W Edwards Deming--"Total Quality Management" Since that time we have been successfully questioning the status-quo challenging and empowering our customers, and creating an atmosphere where self-directed activities workplace partnerships and shared clinical outcomes are the norm

The Tuscaloosa Department of Veterans Affairs Medical Center has a primary service area of approximately 245 000 veterans whose average age is 54 years We are a neuropsychiatric primary medical and extended care facility serving veterans in the northern part of Alabama and parts of Mississippi with 507 authorized hospital beds and 195 nursing home beds Hospital beds include 53 acute medicine 6 rehabilitation medicine 95 intermediate medicine and 353 psychiatric beds The Medical Center provides all levels of care in psychiatry primary and secondary care in medicine and extended/nursing home care These levels of care are complimented by specialized professional service programs including for inpatients a 5-bed general purpose intensive care unit a 12-bed Dual Diagnosis program (DDP) a 25-bed Post Traumatic Stress Disorder (PTSD) unit a 12-bed Geriatric Evaluation and Management (GEM) Program Electroconvulsive Therapy Clozaril Therapy a Geropsychiatric Unit Dementia Care Respite Care Dysphasia Treatment and a Pulmonary Function Laboratory For Outpatients Community Residential Primary Care Clinic Rainbow I Primary Care Clinic Women Veteran Primary Care Clinic Psychiatric Walk-in Clinic Polypharmacy Clinic Community Service Programs (CSP) -- 5 satellite offices in North Alabama Outpatient Substance Abuse Clinic (OSAC) and Post Traumatic Stress Disorder Care Team (PCT Many of our specialized programs units and clinics have been local initiatives designed in concert with the evolving needs wants opinions and attitudes of our veteran population

In FY 93 our Medical Center had an outpatient workload of 503 175 visits and an inpatient workload of 3 302 total admissions with an Average Daily Census (ADC) of 579 8 for both hospital and nursing home care unit beds The Medical Center has an FTE authorization of 1 005 8 and an annual budget of $52 700 000 The employee base includes a wide range of educational levels and career fields including physicians nurses social workers therapists engineers personnel specialists procurement officials clerks planners etc The vision of this Medical Center is to Be the recognized healthcare leader by delivering the most competent compassionate service possible to all customers Our sustained Total Quality Improvement (TQI) and enrichment efforts are found throughout all clinical and administrative services in the Tuscaloosa Department of Veterans Affairs Medical Center (See Exhibit A for a listing of our major awards

Back in 1989 top management was reviewing our achievements and planning for the future They knew we provided good quality health care as evidenced by our consistently positive QA results and JCAHO review scores however these old familiar tried and true paradigms were no longer benchmarks for excellence Their vision at that time was to develop health care programs within our mission that would be responsive to the needs of our veteran population and to create an environment where veterans believed that their health care needs were met and they were receiving quality compassionate care Recognizing the strong partnership bond that existed between veterans and our employees they chose the revolutionary yet compatible approach to empower both the veteran customers and the workforce customers to move toward mutually desirable outcomes Hence, Total Quality Management/Improvement was initiated in a manner to effect a longitudinal cultural evolution within Tuscaloosa Department of Veterans Affairs Medical Center that would enhance the delivery of quality health care

Dr Deming and other TQI proponents teach us that only customers can define quality As a part of our cultural transformation into TQI we began to more systematically inquire of our customers what they want and need In 1991 we developed a local initiative to survey our top four customer groups -- patients families employees and volunteers This survey represented a 20% sample of each customer group The methodology chosen was

personalized interviews held face to face whenever possible and by phone, if not. We assembled and trained a cadre of ten employee "volunteers" from various services to serve as interviewers. Patients were randomly selected from patient rosters utilizing a random number table. If a patient was selected to be interviewed that either refused to participate or was unable to participate for some other reason; a replacement was randomly selected from the roster. On some of our long term units this became quite a problem because few patients were functioning at a level that allowed them to participate. In those instances, we interviewed all of the patients that were able to participate. Family members were randomly selected using patient rosters. This sample was obtained independent of the patient sample. The individuals contacted were identified with the help of the patient's social worker. We defined "family member" as any significant other that was actively involved with the patient. Employees were randomly selected from a roster obtained from personnel service. Because we wanted every service represented in our survey, we randomly selected 20% of each service to be interviewed In addition to the survey responses, information was collected regarding the employee's service, grade, shift, and whether or not the employee was in a supervisory position. The volunteer sample was obtained in a slightly different manner. We had a roster of over 300 volunteers, however, conversations with voluntary service revealed that only about 60 of them provided service on a regular basis. It was decided to identify those 60 and attempt to interview all of the regular volunteers for a 100% sampling. Interviews were used to obtain at least three responses to the survey question from each person interviewed. If more than three were given, all were accepted. After the individual was finished responding, the interviewer went back and asked that the responses be rank ordered in terms of their importance. This project went surprisingly smooth and was completed in approximately four months. For further information about our initial TQI customer survey, see Exhibits B & C.

Our initial survey results where published and shared with all employees to sensitize them to customers' satisfaction goals and to empower them to resolve as many issues at the lowest level possible or to know where to refer the customer thereby, reducing red tape. Our primary objective was to improve services and the customers' perception of those services, NOT cut costs. However, we have found that many times improving services can be achieved with a concomitant cost benefit ratio. The results of this survey and our follow up actions revolutionized our approaches to patient care delivery. We initiated an era of true partnership and teamwork that has made customer satisfaction standards an integral part of our strategic planning and resource allocation process; our employee performance evaluation, reward, and recognition systems; all major care delivery processes; and the design and redesign of clinical and administrative services. Therefore, we are confident that we are in compliance with Executive Orders 12862 "Setting Customer Service Standards" dated September 11, 1993, and the Customer Service Basic Principles and Standards developed by the Veterans Affairs Central Office of Quality Management.

Our current customer focus and feedback loop exist throughout our Medical Center. Customer input (both internal and external) is sought through group meetings, patient and family councils, informal surveys, the patient representative, incident reports, and investigations, Quality Improvement Activities, the Director's Forum, suggestion boxes, TQI teams, etc. All employees are advocates/representatives for veterans and their families. They are empowered to take corrective actions within the scope of their authority. When they cannot personally resolve an issue, they will place the complainant in contact with someone who can. Complaints are analyzed and corrected at the lowest possible level. However, complaints of a serious nature or outside the control of the person receiving it are logged on a complaint form and directed to the appropriate person. The Patient Representative logs all serious complaints into an automated data base and examines the data over time to identify trends. Complaints are corrected immediately, where possible. However, if complaints are recurring, then additional corrective actions may be taken. For example, chronic complaints about returning personal clothing to psychiatric patients led to the formation of our first TQI team--the Patient Clothing Team in 1991.

Utilizing the full gamut of TQI processes, this team completely changed and improved the handling of clothing and personal effects on admission to acute psychiatry. Patients now have a choice about marking and laundering their clothing (giving them immediate access instead of waiting five to seven days for their clothing to return) and inventorying and storing their personal effects. As a result, patient satisfaction was dramatically improved; workload in Ambulatory Care, the clothing room and the laundry was reduced; the number of claims for

missing or lost items was reduced with positive impact on Police Service workload. An outgrowth of this process began, in May of 1994, when we began piloting direct admissions to the PTSD unit with resounding positive customer satisfaction according to veterans, families, and staff.

Some of our most dramatic and continuous improvements have come from the ongoing work of the TQI Patient Socialization Team. We improved the therapeutic environment on a long-term psychiatric unit by reorganizing the available space which provided an additional 1,198 square feet for a sectioned dayroom; by redecorating, repainting, and improving the lighting; and by adding a gazebo, privacy fence, and patio furniture to enhance a 15,400 foot courtyard making it accessible for activities for both restricted and full privileged psychiatric patients. The patients and staff participated in choosing the color schemes, furniture, and location of environmental changes. We also increased the attendance in Kinesiotherapy by using incentives to reward patients and recognize the staff's interest and involvement. Then we added sixteen additional groups and/or activities to enhance patient and staff self-esteem, personal growth, and self-confidence. One of the most significant additional groups was initiated by a musically talented nursing assistant who formed a singing group made up of four of the most regressed assaultive veterans on the unit. This singing group, "The Acts" has grown in stature and popularity, seen two of its members discharged from the Medical Center, performed for several Medical Center programs and local community organizations, and was featured during our Senate Productivity and Quality Award and Robert W. Carey Quality Award presentations. One of their most moving performances was in honor of their head nurse winning our local level Secretary's Award for Excellence in Nursing. They sang "Lean on Me" with great pride and fervor at our National Nursing Day Tea. These improvements in the therapeutic environment and highly structured unit milieu have resulted in sustained improvements in patient self-esteem and socialization, improved employee morale, and reduced the number of patient-on-patient assaults by more than 50%.

In large neuropsychiatric medical centers, the management of disturbed behavior involves both prevention and intervention into assaultive behavior with the potential high risk for injury to both patients and staff. Placing a patient into seclusion or mechanical restraints is a last resort treatment to protect the veteran and others. The standards that govern patient rights, customer satisfaction, and JCAHO mandate that we keep these treatment hours to an absolute minimum. We have taken several actions to improve the process of the use of restraint and seclusion. We ensure one level of care throughout the Medical Center by focusing our efforts on prevention and documentation to assure communication shift to shift. A Standard of Care for the Use of Restraint and Seclusion was written. An overprinted physician pre-restraint/ seclusion assessment process note and an overprinted doctor's order sheet was developed. A section on the use of Restraint and Seclusion was incorporated into the Medical Officer of the Day resource book. We conducted inservice education and training for the psychiatric clinical staff on the use of pharmacological interventions with prevention and management of disturbed behavior using both verbal and physical interventions. As a result of these actions, we have reduced the Medical Center's total seclusion hours per annum from 317 in 1984 to 40.45 in 1993--a reduction of 87% with a cost savings in manhours from $3,918.12 to $499.96. We reduced the Medical Center's total restraint hours per annum from 1,230.75 in 1984 to 296.50 in 1993--a reduction of 76% with a cost savings in manhours from $15,212.07 to $3,664.74 for a combined cost savings of $14,965.49 per annum which translates into the equivalent of .6 FTEE manhours per annum. Most importantly, our patients and staff have a much safer and humane environment. During this fiscal year, all incidents of restraint and seclusion use have been 100% compliant with both JCAHO standards and VHA policy.

In one of our nursing home care units, an employee suggested that something be done to reduce the amount of time wasted looking for supplies to perform oral hygiene care for residents needing assistance. A TQI team was formed and developed standardized oral care kits and placed them at the bedside of all extended care patients and nursing home care unit residents who needed assistance with daily oral care. The TQI team time studies revealed that this action reduced the time of oral care delivery by two minutes per patient. This has an overall cumulative effect of saving 3.25 to 6.5 manhours per day or the equivalent translation to a savings of .57 to 1.1 FTEE comulative manhours per annum.

A clear demonstration of the Center's commitment to Total Quality Improvement was the establishment of an experimental interdisciplinary self directed work group on one of our acute psychiatric units. All full-time employees providing service to the unit were aligned under a single unit manager who reported directly to the Chief of Staff. The "Horizontal Realignment Unit" was initiated on April 6, 1990 for a trial period of one year. It gave ownership of the unit to the employees, including budgetary controls, empowering them to make changes needed for improvement of services at the unit level without having to go through the traditional lines of authority. Nontraditional tours of duty, coverage, and care delivery were utilized. An experimental awards system was designed with the goal of reducing sick leave, avoiding lost time accidents, saving overtime, and promoting team work. The results were outstanding. Overtime cost savings for one year equaled $6,673.52; sick leave hours were reduced a total of 660.75 hours from the previous year; the employee accident rate was reduced 55%; patient assaults were lower; morale and productivity were up; and there were no patient/family complaints during the trial period. In 1993, as a local initiative, we opened a 25-bed Post Traumatic Stress Disorder (PTSD) Unit. All staff assigned to the unit requested to go. The interdisciplinary team members and veterans have formed a unique partnership resembling a self directed work team to assure quality care and customer satisfaction. The Nursing staff designed and implemented 12-hour tours to ensure continuity of care and increase patient/staff interaction. They voluntarily began direct admissions and have made it a resounding success. They negotiated with Pharmacy via a staff suggestion to maintain multidose pass medications (inhalers, insulin, etc.) from pass to pass creating a cost and manhour savings for Nursing and Pharmacy.

With the nationwide shift of emphasis/focus to outpatient treatment and the concomitant increase in our outpatient workload; we have responded by utilizing our patient and family customer survey results, partnership initiatives, and self directed work team tenets to improve services and accessibility of treatment, ensure customer satisfaction, and reduce costs. The Rainbow I Primary Care Clinic was initiated February 6, 1994, with a Primary Care Team consisting of a Physician, Nurse Practitioner, Licensed Practical Nurse, and a Medical Clerk. The team members are available to assist the veterans with their total healthcare concerns, problems, and questions regarding treatment in one primary care clinic on a continuous basis. The staff, as a self directed work group, ensure the provision of continuity of care, use new approaches to treatment, and utilize interdisciplinary resources (Medical, Nursing, Social Work, Psychiatry, Psychology, Pharmacy, Rehabilitation Medicine, Dietetics) to provide competent compassionate care. This Clinic ensures easy access for each veteran to his/her Health Treatment Team. The patient always knows who his/her physician and team will be each time he/she seeks treatment/care The Rainbow I Clinic veterans and their families are very vocal about the efficient and compassionate manner in which their total health care is delivered.

The Community Residential Care Primary Care Clinic was initiated on November 11, 1993, to provide comprehensive care to this high risk population of chronically ill veterans who reside in Residential Care Homes in our local community. This clinic utilizes interdisciplinary approaches to meet the Community Residential Care patients' complex needs. In the past, addressing the health care needs of these veterans was fragmented and required numerous trips to the Medical Center to obtain needed treatments. The goal of this Primary Care Clinic: to treat the veteran holistically and improve customer satisfaction is being met. The patients are being seen by medical, nursing, psychiatry, optometry, pharmacy, dental, dietetics, and social work. Group home sponsors are included in the clinic to assure continuity of care. Research is being completed by involved staff on patient education, continuity of care, and overall customer satisfaction. To-date, all 180 Community Residential Care veterans have been evaluated and treated in this Clinic. Group home sponsors as well as veterans believe that the continuity of care provided in this primary care clinic "...is a Godsend" and has saved time, money, and frustration by focusing on their specialized needs in an organized manner.

Our patients asked to receive and benefit from the treatment they came to the Medical Center for; to be treated with respect, to have the right medications prescribed, and to have their special needs met. Our patients' families asked for periodic progress reports regarding their veteran's status from a staff member knowledgeable about the veteran who will share any changes in the veteran's condition or treatment; to be treated with kindness and respect; and to receive educational information concerning diagnoses, medications, and prognosis. Our two newest primary care clinics are providing all that was requested and more. Early

TQI statistics show an average 25% reduction in the General Medical Walk-In Clinic visits since the initiation of these two primary care clinics.

Tuscaloosa VAMC and Birmingham VAMC (a tertiary general medicine and surgery facility), formed a collaborative partnership using TQI principles to increase quality patient care delivery for our shared veteran customers. As a result, we were able to improve CT scan and ultrasound availability and decrease non-VA costs from having these expensive tests performed and interpreted in local non-VA facilities. An analysis of expenditures for CT scans and ultrasounds for the first and second quarters of FY 94 revealed a savings of $179,022 12 on CT scan interpretation and a savings of $31,280.00 on ultrasound exams. In addition, our two facilities have joint membership on a TQI Patient Transportation Team working together to resolve veteran and staff issues and concerns regarding transporting veterans to and from our medical centers for specialized treatment Meetings are alternated between the two facilities One of the best outcomes has been the improved relationships between staff who communicate daily by telephone and a greater commitment to work together to resolve issues and patient complaints "on the spot " Veterans, families, and staff in both medical centers are more satisfied and improvements are still being made

Tuscaloosa VAMC also actively networks in our local community with healthcare facilities and providers, local businesses, schools, universities, etc

Our workplace culture is team oriented Our team cohesiveness and successes have evolved through the development of trust, equity, open communication, and collaborative activity Our expectation is involvement and investment in mutually desirable outcomes Our transformational leaders include top management, mid-management, union members, patients, families, volunteers, direct care providers, etc We are enhancing people skills and making a paradigm shift by moving from structured line authority to personal power In the One Minute Manager, Dr Ken Blanchard defines personal power as having power with people, not over people Our current Acting Medical Center Director and Chief of Staff, Dr Kirit Shah, is leading us further into Total Quality Improvement by his consistent unwavering focus on our veteran population perceiving that they are treated with respect and dignity while receiving compassionate care He has established Town Hall meetings with interdisciplinary staff in their work area In these Town Hall meetings, he effectively role models open communication, effective compliment and complaint processing and sustains our total quality improvement momentum

Further evidence of our emphasis on TQI and customer satisfaction includes

- Pharmacy Service established a "Pharmacy without Walls" in Ambulatory Care to provide face to face patient/family education about prescribed medications while the prescriptions are being filled

- Voluntary service, in concert with Social Work Service, developed our "tel-care" program to collect customer satisfaction data from veterans and their families following discharge from the Medical Center Complaints, compliments and suggestions for improvements are reviewed by the affected services who take the appropriate corrective/implementation action

- The Women Veteran Advisory Committee and Ambulatory Care developed our Women Veterans' Clinic to provide a full range of care including initial assessment, preventive health care, acute and chronic biopsychosocial care OB/GYN care and counseling, referral coordination and patient/family health education One of our female nurse practitioners follows the female veterans during both inpatient and outpatient care

- Our Center's Horticulture Therapist (HT) works with residents in all three of our nursing home care units in cultivating flower and vegetable gardens They team up with Dietetic Service to serve the vegetables at a special meal, with their flowers as table decorations, and families as invited guests The HT teaches a gardening skills group in our PTSD program Our veterans industries patients help grow plants and place them on patient care units throughout the Medical Center

- Our "Forklifters" program recruits Tuscaloosa Department of Veterans Affairs Medical Center employee volunteers to assist feeding nursing home care unit residents who need assistance and/or are lonely. The program is successfull into its second year.

- Our Center has a major commitment to facilitating the "self help" component of health care services for veterans and their families. One of our Social Workers conducts a bi-weekly Dementia/Alzheimer's Family Support Group with a strong education focus. Once per quarter, she conducts an orientation group for new families to help their transition into our Medical Center. Our Associate Chief Nurse for Psychiatry and a Social Worker conduct a weekly evening Family Therapy Group in our Center's PTSD program. Spouses, parents, children, siblings, and significant others, join their veterans to network and learn more about living and coping successfully with PTSD.

- We improved services to enhance the quality of life for a young quadriplegic resident in one of our nursing home care units. He enrolled in Junior College computer courses. Several employee volunteers transported him to and from classes with an occasional dinner out. He is enhancing his computer skills by completing projects for various services in the Medical Center via our Incentive Therapy Program. He typed the cookbook prepared by nursing home residents and families that was sold to raise money for resident projects.

- We are committed to enhancing the availability of quality patient/family health education. Several of our administrative staff are "volunteering" time to teach patient/family health education classes in Ambulatory Care and inservice education classes for staff. One of our psychologists has initiated a Therapeutic Dance Education Group in our Dual Diagnosis Program. With the assistance of several female employee "volunteers" from our administrative services, he teaches veterans the latest dances

Mr Chairman, Committee Members, and Staff; to summarize; Our health care roles are being transformed as we speak Improving services to veterans through initiatives and innovations is paramount to our very survival in the context of Health Care Reform and "Reinventing Government." We at the Tuscaloosa Department of Veterans Affairs Medical Center are doing this daily. We have created an atmosphere of employee empowerment, customer satisfaction, and self directed team-work by continually responding to customer feedback. The true measure of our worth is found in the unsolicited comments from our veterans and their families, about our competent compassionate care, how vested our employees are in their work, and how interested we are in them as people Each of us--you, as our elected officials, and we, as your health care providers, are working together to develop radical new concepts of workplace culture, relationships, politics, quality, and customer satisfaction. Together we are forging an organizational mind set that serves as the foundation for empowerment and work redesign. We are proud to be your partners in assuring that two of our most important groups of shared customers--veterans and their families--receive the health care they want, need, and deserve.

Thank you.

EXHIBIT "A"

TUSCALOOSA VA MEDICAL CENTER AWARDS
(for last 5 years)

1989

Veterans Health Services and Research Administration Award for Excellence in Public Affairs (Audiovisual Production Category)

1990

Presidential Rank Award Meritorious Executive

1991

VA Innovative Management - Recognition for outstanding vision and creative leadership

Medical Care Cost Recovery - Outstanding performance for collections over $1,000,000

President's Council on Management Improvement Award - Demonstrating and promoting government management excellence

President's Council on Management Improvement Council Member's Award

Congressional Record, 102nd Congress, June 27, 1991, House of Representatives Tribute for being recipient of 1991 President's Council on Management Improvement Award for Management Excellence

1992

Department of Veterans Affairs Secretary's Award for the Advancement of Nursing Programs

Outstanding Contributions to Professional Nursing Education by Capstone College of Nursing

E. O. McClusky Award for promoting issues and programs that encourage quality health care by Alabama State Nurses' Association

Department of Veterans Affairs Commendation for outstanding achievements in Quality Management

Department of Veterans Affairs recognition for having trained 90% of supervisors in 8 hour Supervisors Safety Training Course

1993

Alabama U.S. Senate Productivity and Quality Award - June 1993, Tuscaloosa VAMC was awarded the second place in the Service Sector Category

Secretary of Veterans Affairs Robert W. Carey Quality Award - October 1993, Tuscaloosa VAMC was the winner of the Health Care Category

EXHIBIT "B"

Patient Survey

In order to improve our service to veterans, we are talking to some patients to find out what is most important to them when they come to this hospital. If you agree to talk to me, your answers will be kept strictly confidential. Please feel free to be open with me.... we are just trying to be able to serve you and other veterans better. How would you complete this sentence?

When a veteran comes to this (hospital/nursing home), he/she expects.....

(What things are most important to you while you are a patient in this hospital?)
(What does the staff or administration do for you that you find helps you the most?)
(Can you give me some examples of [pt's own words])
(How do you know when your getting [pt;s own words])

. . . . . .

Family Survey

In order to improve our service to the families of our veterans, we are talking to some family members of our patients to find out what is most important to them when they have someone in our hospital. If you will agree to talk to me, your answers will be kept strictly confidential. Please feel free to be open.... we are just trying to be able to serve our veterans and their families better..... (obtain consent) .....How would you complete this sentence?

When a person has a family member in the VA hospital, he/she expects.....

(What things are most important to <u>you</u> while you have a family member in this hospital?)
(What do we do for <u>you</u> that <u>you</u> find most helpful?)
(Can you give me some examples of [family member's own words]?)
(How do you know when your getting [family member's own words]?)
(What kinds of things happen when [family member's own words]?)

. . . . . .

Employee Survey

In order to improve our service to employees, the quality council is conducting interviews to find out what is most important to the people that work in this hospital. If you will agree to talk to me, your answers will be kept strictly confidential. Please feel free to be open with me.... we are just trying to be able to serve you and other employees better..... (obtain consent) ....How would you complete this sentence?

An employee brags about working at this hospital when.....

(What things other happen or could happen here that would cause you to brag about working here?)
(What things are most important to you as an employee at this hospital?)
(What do especially like about working here?)
(Can you give me some examples of [employee's own words]?)
(How do you know when your getting [employee's own words]?)
(What kinds of things happen when [employee's own words]?)

. . . . . .

Volunteer Survey

In order to improve our service to our volunteers, the quality council is conducting interviews to find out what is most important to the people that volunteer their time in this hospital. If you agree to talk to me, your answers will be kept strictly confidential. Please feel free to be open with me.... we are just trying to be able to serve you and other volunteers better..... (obtain consent) .....How would you complete this sentence?

When a person volunteers at the VA, he/she expects.....

(What things are most important to you while you volunteer at this hospital?)
(What does the hospital or its employees do for you that you find most helpful?)
(Can you give me some examples of [volunteer's own words]?)
(How do you know when your getting [volunteer's own words]?)
(What kinds of things happen when [volunteer's own words]?)

EXHIBIT "C-1"

Patient Survey Results

Top 5 Responses for Total Sample Combined

#1. To receive treatment for what the veteran came in the hospital for.
#2. To be treated with respect.
#3. To benefit from the treatment received.
#4. To have the right medications prescribed by the physician.
#5. To have their special needs attended to and met.

Top 5 Responses for Long Term Care Units

#1. To receive treatment for what the veteran is in the hospital for
#2. Having their special needs attended to and met.
#3. To be treated with respect.
#4. Getting good food.
#5. To benefit from the treatment received.

Top 5 Responses for Acute Medical Units

#1. Medications given as prescribed by physician (no medication errors).
#2. To receive treatment for what the veteran is in the hospital for.
#3. To benefit from treatment received.
#4. Having their requests met in a timely manner.
#5. Being discharged when they are ready to go.

Top 5 Responses for Acute Psychiatry Units

#1. To be treated with respect.
#2. To have the right medications prescribed by physician.
#3. To receive treatment for what the veteran is in the hospital for.
#4. To benefit from treatment received.
#5. For staff to show a caring attitude.

EXHIBIT "C-2"

Family Survey Results

Top 5 Responses for Total Sample Combined

#1. To receive periodic progress reports from the hospital about how patient is doing.
#2. To be able to talk with knowledgeable staff member about the patient.
#3. To be treated with kindness and respect by staff.
#4. To receive educational info about diagnosis, medications and prognosis.
#5. To be notified of any change in the patient's condition or treatment.

Top 5 Responses for Long Term Care Units

#1. To receive periodic progress reports from the hospital about how patient is doing.
#2. To be treated with kindness and respect by staff.
#3. To be able to talk with knowledgeable staff member about the patient.
#4. To be notified of any change in the patient's condition or treatment.
#5. To receive educational info about diagnosis, medications and prognosis.

Top 5 Responses for Acute Medical Units

#1. A sense of caring and understanding from the staff.
#2. To be able to talk with knowledgeable staff member about the patient.
#3. To receive periodic progress reports from the hospital about how patient is doing.
#4. To be notified of any change in the patient's condition or treatment.
#5. To be treated with kindness and respect by staff.

Top 5 Responses for Acute Psychiatry Units

#1. To receive periodic progress reports from the hospital about how patient is doing.
#2. To receive educational info about diagnosis, medications and prognosis.
#3. To be able to talk with knowledgeable staff member about the patient.
#4. To be able to visit the hospital frequently (flexible hours).
#5. To be involved in the patient's treatment and treatment planning.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

IMPROVING VA SERVICES TO VETERANS:
INITIATIVES AND INNOVATIONS
IN THE DEPARTMENT OF VETERANS AFFAIRS

AUGUST 3, 1994

QUESTIONS FOR MR. THOMAS L. AYRES
DIRECTOR
VA MEDICAL CENTER
AUGUSTA, GEORGIA

Question 1: What are the most important lessons you've learned about VA providing better services to veterans which could be utilized by other VA facilities?

Answer: One of the most important lessons that I have learned is the need for a direct channel of communication and mediation between medical center management and individual patients, their families and other consumer groups. Since we strive to provide the best quality of care possible for our veterans, we should not overlook or ignore their viewpoints on how well these services are being delivered.

Question 2: How can VA medical center directors be best encouraged to improve services provided to veterans?

Answer: The most effective way would be developing patient relations performance elements within each medical center director's performance standards. Each medical center director would be evaluated annually by their Regional Director on their performance in this area.

Question 3: What steps should VA medical center directors take who want to improve services to veterans and increase patient and employee satisfaction?

Answer: I believe the best way to improve services can only be accomplished by including veterans and employees in the decision making process, monitoring patient satisfaction and taking timely remedial actions, where warranted.

Question 4: What skills and training do VA medical center directors need who want to improve services to veterans and increase patient and employee satisfaction?

Answer: Medical center directors need a variety of skills and training to function effectively and provide leadership to the medical center. I believe medical center directors should be people oriented since they interact with a wide variety of groups and individuals. In addition, I believe communication, mediation, conflict resolution and counseling skills are imperative.

Question 5: How are medical center efforts to improve services to veterans and increase patient and employee satisfaction being encouraged or discouraged by VA Central Office, VHA and Regional Office top management?

Answer: VA Central Office and Regional Office top management have been and continue to be supportive. Their support is demonstrated through a wide variety of national and regional training programs, development and field testing of the national patient representative tracking program, numerous quality assurance programs, development of national patient satisfaction surveys, implementation of the Secretary's Putting Veterans First program and many other customer/employee initiatives.

Question 6: How could VA Central Office, VHA and Regional Office top management encourage medical center efforts to improve services to veterans and increase patient and employee satisfaction?

Answer: Continue proactive development of patient satisfaction indicators, encourage sharing of successful and innovative patient services programs, and recognize the initiative of medical center management in these areas.

Question 7: Describe any financial disincentives which discourage VA medical centers from providing improved services to veterans and increasing patient and employee satisfaction?

Answer: Medical centers must rely on discrete appropriations to improve services and the timeliness of those services. A broader spectrum of funding mechanisms would give directors greater flexibility in managing resources to improve patient satisfaction and employee morale.

Question 8: Please provide several examples of changes in medical center policies or procedures which have been made as a result of veterans using the patient representative program.

Answer: As a result of veterans using the patient representative program several local policies and procedures have been changed or modified. Specific examples have involved treatment issues, parking, medical center visitation, patient rights, admission and discharges, clinic waiting time, pharmacy operations, medical records, etc.

HONORABLE TOM RIDGE
QUESTIONS SUBMITTED FOR RECORD
MR. THOMAS L. AYRES, DIRECTOR
VA MEDICAL CENTER
AUGUSTA, GEORGIA
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
AUGUST 3, 1994

Question 1: Please further describe the position of patient representative. Is this a separate job classification or is this designation considered to be additional duties or an additional job assignment for those volunteering to do so?

Answer: The position of patient representative is a separate job classification. This position was developed solely to deal with concerns of patients, their families and other consumers. The position is not compromised with additional assignments.

Question 2: What, if any, are the distinctions between an ombudsman and a patient representative?

Answer: At the Augusta VA Medical Center the patient representative program does have some components of the ombudsman's role. The patient representative seeks to balance the interest of patients, staff and administration. Patient representatives advocate and represent the patient's position regardless of personal beliefs and prejudices. Patient representatives have the authority to cross organizational lines of authority to resolve patient concerns and complaints.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

IMPROVING VA SERVICES TO VETERANS:
INITIATIVES AND INNOVATIONS
IN THE DEPARTMENT OF VETERANS AFFAIRS

AUGUST 3, 1994

QUESTIONS FOR DR. ROBERT R. RHYNE
DIRECTOR
VA MEDICAL CENTER
GRAND JUNCTION, COLORADO

Question 1: What are the most important lessons you've learned about VA providing better services to veterans which could be utilized by other VA facilities?

Answer: The provision of care by one practitioner or one team has increased the continuity of care to our veterans. The veterans' continuous contact with the same providers promotes a higher level of care and increased familiarity with the individual veteran's needs. There is a decreased risk of conflicting therapeutic regimes being initiated during treatment.

Question 2: How can VA medical center directors be best encouraged to improve services provided to veterans?

Answer: Improvement of services should be a key element within each director's performance requirements. Improvements must be ongoing and measurable against defined standards.

Question 3: What steps should VA medical center directors take who want to improve services to veterans and increase patient and employee satisfaction?

Answer: Directors must set a top down example to all medical center employees. Strong channels of communication are vital and must provide opportunity for patient and employee input. There must be visible evidence of commitment through such means as:

a. A Strong Patient Representative Program
b. Total Quality Improvement (QT) Action Groups
c. Employee Empowerment
d. Sharing of Performance Measurement Information
e. Medical Center Involvement with Community, Business and Veterans Groups
f. A Strong Public Relations Program for Internal and External Customers
g. Incentive Awards Programs

Question 4: What skills and training do VA medical center directors need who want to improve services to veterans and increase patient and employee satisfaction?

Answer: Skills and training needs include the following:

a. Public Relations
b. Veterans Advocacy/Patient Representative
c. Communications
d. Team Building
e. Strategic Planning/Marketing
f. Sensitivity Training
g. EEO

Question 5: How are medical center efforts to improve services to veterans and increase patient and employee satisfaction being encouraged or discouraged by VA Central Office, VHA and Regional Office top management?

Answer: VA Central Office (VACO) and Regional Office top management continuously emphasize the need to increase patient and employee satisfaction. Innovative efforts are encouraged and when available, additional resources are provided. In addition, awards and other incentives are given to medical centers demonstrating achievements in these areas.

Question 6: How could VA Central Office, VHA and Regional Office top management encourage medical center efforts to improve services to veterans and increase patient and employee satisfaction?

Answer: There is little else VACO and Regional Office top management could do other than to provide additional resources for innovative efforts. Unfortunately, the Veterans Health Administration (VHA) budget does have its restrictions. In addition, where feasible, decentralization of decision making authority could streamline and encourage innovative efforts.

Question 7: Describe any financial disincentives which discourage VA medical centers from providing improved services to veterans and increasing patient and employee satisfaction?

Answer: The only financial disincentive is having sufficient resources to offset any increased cost that may result from improved services.

HONORABLE TOM RIDGE
QUESTIONS SUBMITTED FOR RECORD
DR. ROBERT R. RHYNE, DIRECTOR
VA MEDICAL CENTER
GRAND JUNCTION, COLORADO
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
AUGUST 3, 1994

Question 1: You say that the real success of your Primary Care Model is demonstrated in decreased hospital admissions, that while you have experienced a 38 percent increase in the number of patients treated, your medical admissions to the hospital have declined by 11 percent. Do you believe similar results can be achieved in a more urban setting?

Answer: It would be pure speculation regarding the viability and effectiveness of the Primary Care Model in an urban setting. A modified version is being planned for implementation in VA Medical Center Phoenix, Arizona; however, there are no results available regarding the model's effectiveness in an affiliated urban setting.

Question 2: Please describe your facility's transition to ambulatory care within the confines of the current eligibility rules?

Answer: In 1987, the medical center was organized into two separate entities, ambulatory medicine and inpatient medicine. All outpatients were seen in General Medicine Clinic and General Medicine Overbook Clinic. Clinic was held five days a week. Patients were seen again and again with multiple volumes of charts. Laboratory tests and x-ray examinations were ordered and the patient was scheduled to return to another General Medicine Clinic appointment where a different provider asked the same questions, ordered some of the same tests, and the cycle was repeated. It was clear that we had to find a better way to deliver care. A group of physicians, nurses, and Medical Administration Service personnel came up with the Primary Care approach, and a trial team of one internist, one nurse, and one Medical Administration Service clerk tested the concept for several months. The concept worked well and in July 1988 the Primary Care Model was introduced to our patients. Every veteran with a pending General Medicine Clinic appointment was given an appointment with a team consisting of a physician, nurse, and Medical Administration Service clerk. The patients now had a doctor who would treat them in the clinic and admit and care for them in the hospital. The patients realized there was always someone to call on to discuss a problem or to make an appointment. This system works well within the confines of the current eligibility rules. Emergencies are first priority, then scheduled patients, and then walk-in patients. Waiting times are reduced because the workload is more evenly distributed among the physicians. Unscheduled visits have dropped from 42 percent of all visits in 1987 to 10 percent in 1993. We have such a large mandatory veteran patient population, we are unable to provide care to discretionary veterans due to unavailability of resources.

Question 3: Please describe remote distance transfers? Would it be cheaper to use the services of the local community hospitals for specific services? Has there been a comparison made between the cost of transferring VA patients to other VA facilities with purchasing those services directly from the community?

Answer: Emergency, remote distance transfers are accomplished by air ambulance. Denver and Salt Lake City are each about 250 miles away. Non-emergent transfers are accomplished by commercial air. The average cost of air ambulance transfer to

either Denver or Salt Lake City is $1500, and the average cost of a commercial flight is $200. Another factor to consider is that services such as open-heart surgery, spinal cord injury treatment, and transplants are not available in Grand Junction. While no specific cost comparison has been made, we feel the cost and benefits of transferring veterans within the VA system is much more cost-effective than using the services of local community hospitals. We do purchase many services from the local hospitals and medical community such as radiation therapy, pathology services, podiatry, neurology, urology, and orthopedics. A total of $210,645 was spent with a local community hospital in FY 1993.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

IMPROVING VA SERVICES TO VETERANS:
INITIATIVES AND INNOVATIONS
IN THE DEPARTMENT OF VETERANS AFFAIRS

AUGUST 3, 1994

QUESTIONS FOR MR. BARRY L. BELL
DIRECTOR
VA MEDICAL CENTER
PORTLAND, OREGON

Question 1: What are the most important lessons you've learned about VA providing better services to veterans which could be utilized by other VA facilities?

Answer: While there are many things we can do to improve our system, one of the most important is to get to know the private sector in our community. There is a tendency to shield ourselves from private sector realities because we rationalize that we have different personnel, accounting and procurement rules.

While there are many good VA medical centers, the standards we need to aim for are not VA norms, but the best and most innovative wherever we find them. This most often is found in private community facilities where patrons of those facilities can and do change providers if not completely satisfied with the timeliness, quality of services and cost of care.

VA medical facilities by and large are conscientious about the quality of care they give. They are also conscientious about the compassion and concern they show toward the veterans they care for. But for the most part they aren't aware of the state-of-the-art in private sector service delivery.

I believe that to achieve a quantum leap in our service delivery we need to benchmark against our community's standards. We need to ask are our availability of appointments as responsive as the community has available to its patients. We need to review community standards for benchmarks not separate and isolated VA norms.

Question 2: How can VA medical center directors be best encouraged to improve services provided to veterans?

Answer: Make service delivery the standard by which we are measured. Stop making isolated rules and procedures the criteria of measurement of whether we are doing the job correctly. We are required to monitor hundreds of minute rules in Fiscal, Medical Administration Service (MAS), and Acquisition & Materiel Management (A&MM) as an example. If we follow those rules we are judged good even if the outcome is less than we could otherwise achieve. If we fail to follow prescribed rules we are scolded even though we have achieved a superb outcome. This discourages innovation and creativity.

Question 3: What steps should VA medical center directors take who want to improve services to veterans and increase patient and employee satisfaction?

Answer: There are some individuals and medical centers who achieve innovation (often by ignoring the rules), but these innovations are not well known throughout the system. This is

for two reasons; 1) we have a poor system of communicating breakthroughs in service other than word of mouth, 2) if we had to violate rules to achieve the outcome we tend not to publicize our actions less we be reigned in.

Question 4: What skills and training do VA medical center directors need who want to improve services to veterans and increase patient and employee satisfaction?

Answer: We need to spend more time learning of private sector activities. I believe VA medical center executives have good skills.

Question 5: How are medical center efforts to improve services to veterans and increase patient and employee satisfaction being encouraged or discouraged by VA Central Office, VHA and Regional Office top management?

Answer: With support from Congress, VHA could lift some of its more restrictive rules and directives and allow medical center directors to have more flexibility in operating and managing resources.

Question 6: How could VA Central Office, VHA and Regional Office top management encourage medical center efforts to improve services to veterans and increase patient and employee satisfaction?

Answer: Eligibility rules could be clarified to improve understanding of benefits by both employees and patients and thereby improve patient and employee satisfaction.

Question 7: Describe any financial disincentives which discourage VA medical centers from providing improved services to veterans and increasing patient and employee satisfaction?

Answer: Personnel floors and ceilings combined with FTE restrictions is an inane way of managing. The private sector is assign budgets based on revenue and goals. The managers are expected to live within those budgets.

Our contracting rules were legislated with $500 hammers in mind not health care services. We are driven by attentiveness to procedure not outcome.

HONORABLE TOM RIDGE
QUESTIONS SUBMITTED FOR RECORD
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SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
AUGUST 3, 1994

Question 1: Given the success of the Women Veterans Health Clinics, the Day Unit, and the Primary Care clinics in Ambulatory Care at the Salem VA Medical Center, which you outline in your testimony, would you give the Subcommittee your recommendation(s) for improving services to women veterans throughout the VA medical care system? Specifically, what would be your number one recommendation?

Answer: Women's health care at the Salem VA Medical Center has been vastly successful because of the support provided from the Director, the Associate Director, the Chief of Staff, and the Associate Chief of Staff for Nursing. In my opinion, a major change that could be made to improve services to women veterans throughout the VA medical care system would be to obtain the support for program development and resource allocation from administration at each facility. Success or failure of a new program, such as women's health care, to a large degree depends upon the commitment and support, or lack of the same, from the management team. The concerns that have been expressed to me by individuals working in clinics where program development and implementation has been less than optimal reflect a lack of commitment and support from management. Veterans Affairs medical centers must consider women's health care a necessity instead of an option.

Question 2: Would you say that there is need for expansion of legislation to improve the quality of women's health care delivery services, or would you say that the problem of care lies in the implementation of current law and regulation?

Answer: The problem of health care delivery services to women, in my opinion, lies primarily in the lack of education and/or understanding of current law and regulation. It appears that each medical center has its own interpretation of services which should be offered to women. Providing top management and Regional/Local Female veterans Coordinators with copies of the current law and regulations and education regarding expectations will potentially enhance the quality of care to women veterans.

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